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VOL. XXIII JULY, 1925 No. 7

SOME MEDICAL CONVICTIONS AND MEDITATIONS *

By GRANVILLE MACGOWAN, *Los Angeles*

THIS year your president will be satisfied in directing your attention to a few subjects with relation to our internal affairs, our life as a medical body, which he believes are worthy of your attention:

Permanent quarters for the California Medical Association; attitude of the profession toward what constitutes the practice of medicine; problems of industrial medicine; progress in the treatment of internal diseases; the Eighteenth Amendment; Revenue Act of 1924.

FELLOW-MEMBERS of the California Medical Association—Last year, at the time of our Meeting, I was filled with a message that required a long and carefully prepared dissertation showing a very acute danger which I thought threatened the American public—a danger arising out of a trustful carelessness and a lassitude towards public duty. Since then we have passed through a political campaign in which the powers of darkness did their best to capture the American Government through the ballot-box. Thanks to warnings given by many men placed in similar positions as myself, these people found the American voting populace prepared—it had been cautioned—it would have none of the Soviets. But do not believe that the danger I portrayed is chimerical—stand fast; be true; be watchful. This country is one of party government. If the salvation may not be found in one or other of the two older political parties, then it will not be found outside of them. It will not be found in Communism.

This year your president will be satisfied in directing your attention to a few subjects with relation to our internal affairs, our life as a medical body, which he believes are worthy of your attention.

We are gathered here today in this beautiful valley of the Yosemite, the wonders of which were first portrayed to the world by an humble medical man, serving in a semi-military capacity. As we look about upon waters, cliffs, the great forests and the lush grasses of the meadow land, we awaken to the fact that we are isolated from the great cities—away from the hum of trade—we are in the country, where we can relax and enjoy ourselves and breathe the pure air. How many of you think that it would be delectable to have our own place in the country—to have a home to which we could go, where we would be free for a season each year from the inroads of the outside world—where we could be among ourselves, and have a place that belongs to us, which might be used by ourselves during our lifetime and kept intact for the benefit of the California Medical Association for many decades—a place of recreation and a place where we could hold our meetings and transact our annual business away from the hurry and crowding of our busy marts? There is among us one man—a marvelous business man for a physician, one who thinks of the comforts of the individual members of the California Medical Association—one who thinks in terms of the welfare of his own local society, and who has by precept and example and by persuasive ways built up the personnel of the Los Angeles County Medical Society. Dreaming of a home, an abiding place for this county society, when we did not have a dollar for it, he has today very nearly approximated the ideal which he set out to attain, and in this he has had pretty nearly the united support of the members of his society. He has dreamed further—he is still dreaming. We do not care to wake him up, because we wish to see his dream come true. He has interested with him a number of the far-seeing men of the association who desire to secure, at some convenient point in this state, both for those who live in the northern section and those who inhabit the southern portion, a place where we may have our home—a reasonably large place, either with a beach that belongs to us, or woodland with flowing streams, where we may live in tents, where we may have a simple and capacious hall, to which we can invite learned strangers to give to us, while we are entertaining them, some of their precious knowledge—not in a hotel, nor in some caravansary, but in some home of our own. Your President thinks that this is a very vital thing for the welfare of the California Medical Association, and he recommends that each member talk and work towards its achievement.

ATTITUDE OF THE PROFESSION TOWARD WHAT CONSTITUTES THE PRACTICE OF MEDICINE, WHICH IS GREATLY CHANGED FROM WHAT IT WAS FIVE YEARS AGO

Believing as we did when an organized effort was made to cheapen the profession of medicine and lower the standard of the preparation required, in the struggle for the protection of the interests of the

* Address of the President of the California Medical Association, Yosemite, May 18, 1925.

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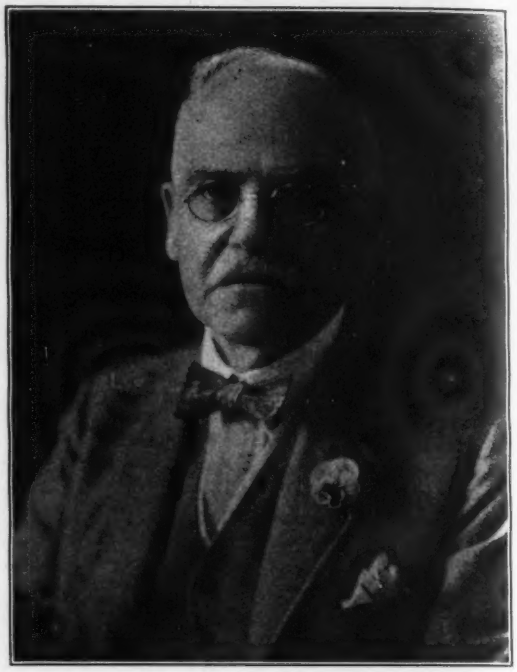
people, such as we understood it, we sought to control political opinion in two bitterly fought campaigns, and in the end we lost our battle, and we lost it for two very potent reasons—one, because there is a very large Pharisaical element among us, an element so greatly impressed by its own present social and professional perfection that it feels its own professional interests to be entirely protected by its intellectual superiority, and that it is not incumbent upon it to guide or influence the public in general for the public good. The second reason was the unwillingness of the average practitioner of medicine to assess himself to pay for the prevention of the success of the chiropractic and osteopathic bills. These latter groups, being well supplied with money and the enthusiasm of the forbidden, gathered up their votes and put their measure through. So we are today living in a regime of medical freedom in California. No one knows exactly what constitutes medical practice; it is not definitely and succinctly defined. Apparently, under present conditions anyone can, without legal danger, prescribe for the sick. The public is beginning to grow into the position where it makes no definite distinction between a learned physician who has with great care and sacrifice of time and money attempted to perfect his art and the charlatan who had never seen the inside of any real medical school, nor listened to the teaching of any real physician. We have, as a body, to a large extent taken the position of our Pharisaical friends, that this is a question which concerns the public itself. Thus we have, as a body, while waiting, unwillingly and with grumbling, accepted the lowering of medical standards. As individuals, some of us have not felt like adopting this attitude. Although the public has shown very clearly by its votes that it does not desire our assistance, yet we have believed that, perhaps, the populace will presently awaken to the errors into which it has fallen, so that in matters of public health, through the League, we endeavor by persuasion and indirection to render the opposition as innocuous as possible, and we hope to accomplish by education, through our organ *Better Health*, which is now a regular journal to be found on all news-stands, what we failed to do by strenuous political combat.

THE DISSENSIONS IN OUR RANKS, BECAUSE OF THE PROBLEMS OF INDUSTRIAL MEDICINE, STILL SEETHE

There is much dissatisfaction as to the present condition of the enforcement of the medical side of the Industrial Compensation Act in the state of California. This is again a question in which the interests of the working man and of the physician are pitted against those of the employer and the insurance carrier, and its intricacies are such that it is very difficult to understand and perhaps even more to alleviate. The attitude of some of the members of the association in this matter is very far from ethical, but it appears to be within the law, and if we do not like it as it is, our remedy is to have the law changed, because this association does not, as a few of its members seem to think, possess any dictatorial power as to who shall be employed upon the panels, or to designate when and how injured people shall be looked after. This brings us around again to the question of attaining sufficient political power, as individuals, to have attention paid to our requests as a body. It is in this way, and this way only, by indirection, that our influence may be felt by those who make and those who enforce our law.



GRANVILLE MacGOWAN
President C. M. A. 1924-1925

We have at the present time a Committee on Industrial Practice which, under the chairmanship of Dr. Hyman, has a plan which your president believes will get you somewhere, if you adopt it. But this plan requires the action of the medical men interested in industrial medicine as a unit, and if there are not too many among you unwilling to deprive yourselves of the pleasure of finding fault and to learn to program for the general good, or if there are not too many Brookharts or La Follettes in our ranks, there is a good chance that this matter will be settled, perhaps, some time before the youngest member of the association dies, should he live out his life expectancy.

It is a common saying, said so many times that it almost becomes trite, that there has been little progress in the medical treatment of internal diseases, as compared with the great changes wrought in pathological conditions which are amenable to the interference of surgery. But this only appears more striking because it is more spectacular.

To the genius of Louis Pasteur, who was only an honorary doctor but the most marvelous chemist of all time and the best friend medicine ever had, our profession owes its ability to accomplish its surgical miracles. It is he who made it safe to change the human frame by alteration, and to mend and darn its tissues without fear of infection and death. If

the mechanical skill is sufficient and enough care is taken to ascertain before operation that the subject has a reasonable metabolic index, marvels may be done in a surgical way, almost without any mortal risk, which were entirely impossible before the era in which the development of the twin sciences of stereo-chemistry and bacteriology were given to a skeptical and not very willing medical world. The research work of this school has in the last thirty years resulted in the discovery of a number of relatively specific remedies which are the pride of our professional life—antitoxin, the active agents of the pituitary and thyroid, and many others.

Along the lines of chemical research, following up the possibilities of the action of the dye stuffs as therapeutic agents in bacterial diseases, worked out chiefly by Ehrlich, Raisus and the Brady Urological Institute, we have been furnished with remedies which makes the life of a properly educated physician of today one of not only great value and usefulness, but also one in which he may feel very proper pride, because although he may not be able to conquer, overcome and heal each and every disease to which the human frame is liable, yet so much has been accomplished and the amount of guesswork so greatly reduced, that modern scientific medicine has much more to it than a college yell.

Many preparations introduced with fervor have fallen by the wayside through the premature claims of those who have discovered them, they not being satisfied to apply, as did Pasteur always, the rigid proofs which were necessary to convince the scientific mind which should always be ready to criticize its own work as freely and as harshly as it criticizes the work of others.

It has been rather well known for a number of years that colloidal preparations of certain metallic elements other than arsenic and mercury have a very active therapeutic influence upon bioplasmic changes. An English syphiologist, a man of very great ability, introduced into medical practice quite a few years ago a preparation of colloidal sulphur which appears to possess to a considerable extent the power of causing the oxidation of minerals retained in the organs of the human system. MacDonaugh firmly believes that intramuscular injections of this substance in those cases of syphilis which obstinately refuse to improve beyond a certain point under mercury or arsenic in any form will, after the moderate use of intramuscular injections, become once again susceptible to the therapeutic action of the luetic trinity of mercury, arsenic, and bismuth. The proof of this has never been sufficiently and accurately demonstrated, for these injections are, in most instances, extremely painful and patients often refuse to continue them sufficiently long to decide their value. It was noticed very recently, I think, purely empirically and perhaps accidentally, that in those cases of syphilis in which there are dermatitis of arsenical origin, they can be overcome or prevented during the prolonged use of arsphenamine or neoarsphenamine by the intravenous use of solutions of sodium thiosulphate, a preparation of sulphur which acts as a colloid. No danger apparently follows these intravenous injections, and it is believed and is reasonably probable that the presence of the sulphur in small amounts in an assimilable form causes oxidation and disappearance of the minerals which are, after long-continued use, deposited in the internal organs of the body. We furnish an agent that is lacking in the system, and in its presence the surplus of these other minerals is disposed of by the biochemistry of the body.

The latest addition to our pharmacopeia is the use of hexyresorcinol for renal suppurations. This preparation, we have found in my office to be very potent, and it looks as if Doctor Young's claims are well founded. This is really only another form of colloidal sulphur. There is no reason why the physician should rest under the imputation of practicing the science of medicine by guesswork alone. It is true, after all, that the chief thing which marks the great physician from those whom he works beside, is the knowledge of human nature—the ability to inspire hope and to drive away gloom and fear. But in addition the psyche must be assisted by some remedies which actually have therapeutic potency and furnish elements much needed by the human laboratory. It is certain that within my lifetime, the number of those remedies upon which we can really depend for relief of our patients in their illnesses has been marvelously increased. The chemist is always on the watch.

There is a subject of general interest—I might almost say of paramount interest—at the present time in the United States which I desire to bring before you. It is one that I approach reluctantly and more or less with timidity because I feel that what I am about to say may perhaps offend some of those whose opinion I value most highly, but nevertheless I cannot see, without protest, our great profession lending itself to what appears to be a civic wrong, the results of which are grave now, and give promise of becoming extremely iniquitous and perhaps disastrous to our nation.

A few years ago, by a combination of well-meaning fanatics, with heartless industrialists whose sole god is that of money, the celebrated Eighteenth Amendment to the Constitution of the United States was put over in the absence from the country of approximately four million young men who were voters. The fanatics, some of whom with most virtuous intent, thought they were acting for the best interests of the rising generation; others, professional uplifters, swayed by the hope of gain and the itch to pose as reformers and to have their names continuously blazoned in the limelight of the daily press, by assiduous work at the polls, often by measures of duress in their dealings with legislative bodies which, if employed for the passing of ordinary bills, would have been regarded as criminal, contrary to public policy and probably punishable by sentence to jail, passed the amendment and a glorious jubilee was announced. The method was rotten, but many believed the end justified the means, and that alcohol once removed from the market place and made difficult to obtain for any purpose and impossible to obtain for beverage purposes would prove to be a great saving influence upon those who had never

been subject to its use, and that crime would be definitely decreased and poverty abolished.

The alliance made with many great employers supplied the money needed for this object, and also in no way decreased the political power necessary to sway the legislatures. Many of us who were not naturally pessimists but inclined to optimism believed that perhaps the demon rum would be permanently abolished and that the high hopes of the advocates of total prohibition would be realized. The governing bodies of many medical associations voted upon this bill approved it and gave it their sanction. But alas! we knew but little of the temptations that such a law would present to those whose duty it became to enforce it. We had no idea of the enormous leverage which it gave to blackmail. We did not understand that so many young men of great physical courage, taught by the war to delight in adventure, would take up the trade or profession, more or less openly, of smuggling and manufacturing intoxicating alcoholic drinks and their distribution in cities, towns, villages, and rural districts. We had no means of knowing how shrewd, unscrupulous business men, forming combinations with courageous, fearless and murderous banditti, would let loose upon us a perfect flood of vilely concocted alcoholic beverages manufactured in Europe or in adjacent countries, inundating our seaboards and flooding the lands nearby our national borders; nor could we foresee to what extent, through connivance with national, state, county, or city officials from one end of this land to the other with these dealers, no one who has the price anywhere from Maine to California, from Canada to Mexico, need be without alcoholic drinks if he has the will to have them.

Gradually the morale of our peace officials has been undermined by the temptations to which it is subjected, so that today the surest way to obtain liquor which is measurably fit to drink consists in forming an indirect alliance with those who are named by the national and local authorities to enforce this law. In witness whereof, we have in the last three years, week after week, seen the dismissal of prohibition officers, policemen, sheriffs, and constables, and in many instances these forlorn individuals who have fallen under corrupt influence set in motion by the Eighteenth Amendment have been committed to the national penitentiaries for a crime which found its excuse only in the fact that "everybody was doing it."

Within these three years I have traveled very extensively in the United States. Nowhere have I seen among the kind of people with whom I would naturally come in contact, and who are exactly the same kind of people who are present here at this gathering, in their houses, in their clubs, and in their learned societies, any absence of alcoholic liquors, the supply of which was unquestionably, in the majority of cases, of illegal origin.

It has been my privilege to attend many social gatherings and often my painful experience to notice the character of drinking that exists among the sons and daughters of the well-to-do—in the dances, private or public, in the country clubs and places of amusement, where boys think it smart to have a flask upon the hip and to use it and offer it to the young girls. And many of the girls themselves have these flasks which are also filled and used. It scarcely requires such observation, because every department store in the land, every dealer of silverware, every druggist, exhibits a vast number of flasks for the holding of illicit liquor to be taken to gatherings where the law may interfere with its being served openly.

At this time our government is engaged at sea in what is practically a civil war for the prevention of smuggling of alcohol—a civil war in which the navy and army are employed for the enforcement of the law; two bodies in which the sentiment, from the highest official to the most recently enlisted man, is almost totally against prohibition and from which it is idle to expect a heart-stirring enforcement.

It is true, or seems to be, that there is less public drunkenness; it is true, or seems to be, that the working class, the mechanics and the day laborers have more money for their families, because the price of alcohol is beyond many of these men, but so high has the daily wage risen in the last five years in America in the building trades especially that, I am told by employers, in many of the shops and factories of the land the bootlegger is a well-recognized individual within their walls and one whom it is impossible for the employers to expel without danger of incurring trouble with their discontented working men who, deprived of their really comparatively innocuous drink of mild beer, feel that their government is not one that cares for the welfare of the working man or his comfort and that they are not on an equality with the rich, who are able successfully to defy the law which bears the name of Mr. Volstead.

This has gradually given rise to an attitude of receptivity by these men to the doctrines of Communism, the agents of which are extremely active, and lose no time in fostering this discontent and sowing in this fertile soil the seeds of trouble.

I have no patent to advocate. We cannot return to the old order of things. The open saloon was a horrible political evil and should not under any circumstances ever be restored. But an iniquitous enactment, as is this amendment, which has made so definite a class distinction in our daily life, and so potently sows the seeds of discontent among the proletariat, and fosters pernicious habits among those who, by reason of their education and social position, will, in the next generation, lead in government and business and installs hypocrisy as a constant feature of our daily life, opens the way wide and full to the encroachment upon our personal liberty by other sumptuary laws, which the cruel Loyolas and Torquemadoes, the austere Algibenses, and the grim and merciless Puritan Sam Parris' witch burners, who exist all around us today as full of zealous and inhuman fanaticism, as ready to satisfy their sadistic natures as they did in the seventeenth century, would make use of every other dear-bought right which we have under our constitution.

While we seem to do the working man good by removing from him the opportunity at will to become a drunkard, we have offset this by the gradual

undermining of our civil honor and respect for law because we lead in our lives a continuous lie and will eventually lose the power of speaking the truth on any matter, and while we count the additional dollars in our savings bank, we forget it can be but little benefit to the individual or to the nation to gain a whole world and to lose its soul.

Now I say, gentlemen, that in the medical conventions which I have attended in many different cities of the Union, in the labor conventions, the proceedings of which I have been familiar with by reason of affiliated interests, in the political conventions of all parties in all parts of the country during the past three years, there has been no end of the supply of liquor that might be used and most of it illegally obtained; and I have noticed among our own people many drinking whom I know I never saw drink before in the old days.

We should not behave towards this very important question as if we were congressmen, because our opinions should not be throttled by the fear of punishment at the polls by the active minority. We should at least be able to say that our lives and actions are an example of our preaching!

I do not recommend and I do not ask that any official action be taken by our association, but I hope that each member shall go home and, in meditation, take earnest communion with himself to determine if the cause of prohibition is worth the price which we are paying.

And finally I have another subject which should be of great interest to you and of great interest to any learned body, the members of which gather together for the sake of improving their knowledge and skill in their respective professions from time to time in conventions held at some distance from their place of residence. You who make income-tax returns have learned with distaste and disgust within the past year that no allowance is made by the bureaucrats in charge of the levying and collection of the income tax for the expenses incident to the attendance of such conventions. The ruling of the department has been that those who are engaged in trades or business should have a per diem for their expenses while away from their homes in attendance on such conventions and for the actual transportation charges, but this is not allowed to doctors, lawyers or architects and several other professions, whose gatherings are looked upon by this department as intellectual junkets, pleasure trips, or social relaxations having no value near or remote to the government.

This ruling of the department incensed your president, and he has been largely influential in having your executive council instruct our attorney to draw up a law to be brought before the next congress for the removal of this defect. Your officers will endeavor to secure the co-operation of every incorporated society of regular physicians in the republic. The law is so drawn that it will cover the same question in meetings of other learned associations.

Following is the law:

Amend Section 214 of the Revenue Act of 1924 (a) (1), as follows:

Section 214 (a). In computing net income there shall be allowed as deductions: (1) All the ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade, business, *or profession,* including a reasonable allowance for salaries or other compensation for personal services actually rendered; traveling expenses (including the entire amount expended for meals and lodging) while away from home in the pursuit of a trade or business, *or profession, or in attending professional conventions of the profession of which the taxpayer is a member.* (The words in italics comprised the proposed amendment.)

I thank you for your consideration in electing me your president for the year 1924-1925 and for your kind consideration, rendering the filling of this office a pleasure instead of a task. I wish my successor as happy and as pleasing a year in office as I have had. His year cannot be so instructing as has been mine, for he has been familiar as a member of the council with the machinery required to keep the association's business affairs in function which I was not, and it is my humble opinion that it is from this body, the council, that presiding officers of the society should always be drawn.

Brack Shops Building.

The Use of Physostigmin in Abdominal Distention—The use of physostigmin in abdominal distention was studied by Hayes E. Martin and Soma Weiss, New York (Jour. A. M. A.), in non-toxic cases in which abdominal distention followed laparotomy, surgical shock, early intestinal obstruction, or injury to the central nervous system, and in toxic cases, in which the condition was associated with peritonitis or general toxemias, such as pneumonia or long-standing intestinal obstruction. In every case various simple measures, such as gastric lavage, enemas, turpentine stupes and colonic irrigation were employed when distention occurred, and physostigmin was not used unless those measures proved ineffective, the purpose being to learn whether physostigmin is capable of relieving these patients. All the patients who received physostigmin were in a serious condition, and all manifested alarming symptoms. All of the sixteen patients embraced in the group of non-toxic cases of abdominal distention were completely relieved of this distressing symptom by the injection of physostigmin. The fifteen patients embraced in the toxic group were benefited but little or not at all. The results of these experiences indicate that the drug should be administered in doses sufficient to induce its characteristic therapeutic effect or until the occurrence of systemic actions indicates that the limits of safe dosage have been reached. Physostigmin is a useful drug for the treatment of abdominal distention in non-toxic cases, especially. It is less useful in cases of the toxic type. It has fallen into disuse mainly because of the employment of insufficient doses, partly, perhaps, because of the failure to distinguish the type of cases in which it is more effective (non-toxic type) from those in which it is less effective (toxic type). The effective dose of the salicylate or benzoate, in cases which do not yield to simple measures, is from 3 to 4 mg. (from 1/20 to 1/16 grain) injected intramuscularly. Such a dose may be repeated once after an hour if the first does not induce any systemic effects, and it may be repeated three times (at least) at intervals of three or four hours if there are no symptoms which indicate that its systemic effects persist. The general condition of the patient and his behavior toward the drug must be observed carefully and must serve as a guide for the repetition of the dose. The dose required for those patients who respond to simple therapeutic measures, such as rectal enemas, has not been determined.

Jud Tunkins says patent medicine ads are so attractive that it makes a man who has his health feel like he was missing something.—Washington Evening Star.

AS THE LAYMAN SEES US*

Cultural Education in Medicine, Specialism, and the Distribution of Physicians

By EDWARD N. EWER, M. D., *Oakland*

CULTURAL education in medicine, specialism, and the distribution of physicians.

Cold science, effective but not always convincing, has come into nursing and medicine, as sentiment has been squeezed out. It has been remarked that, in the beginning, medicine was all art and no science, while now we are trying to make it all science and no art.

MOST of us who have been practicing medicine for a considerable number of years are sometimes troubled at an apparent change from high regard to something like querulous criticism on the part of the public we serve. There is an impression that the esteem in which the medical profession was once held has suffered in recent years. We find laymen here and there addressing medical men on such subjects as The Layman's Impressions of the Medical Profesison; What Is the Matter With the Medical Profession, and like topics.

Conscious of progress and rectitude, we wonder wherein we have fallen from grace. The passing of the old family doctor, revered in story and song, has been the regretful theme of addresses and writings until it almost brings tears to the eyes. Thus do the humanities tug at the heartstrings, and cloud the vision, till progress and scientific achievement are lost to view.

The office picture of the bearded doctor in midnight vigil at the cot of the dying child, hand on chin in troubled thought, doing nothing, but breathing sympathy, had a fine human appeal. Bring the scene up to date, and what would the picture be? White-garbed figures, an impersonal nurse or two, and aspirating needles ready to jab into the infant's spine—efficiency, action, but repelling, a life jerked back from the brink perhaps; but roughly. Cold science, effective but not always convincing, has come into nursing and medicine, as sentiment has been squeezed out. It has been remarked that, in the beginning, medicine was all art and no science, while now we are trying to make it all science and no art.

Those fortunate individuals who have been blessed with cultural influences in their early surroundings, and especially in their educational advantages, still make conspicuous successes by applying their science clothed with human interest and sympathetic concern. Do we wish to encourage this character-forming influence in medical training, or is the whole world becoming so materialistic it is not worth while? Can we be educated and neglect the humanities? It has even been said the quacks get closer to the people than do the physicians; though cultural training, Heaven knows, has nothing to do with this.

One professor of philosophy said: "The satisfaction that many of us laymen get out of going to quacks is, primarily, the comfort of being treated like men instead of like incurious animals. An intelligent layman, in impatience with what he calls the intellectual selfishness of physicians, has recently declared, 'quacks know men, but not medicine; physicians know medicine, but not men.'" Certainly the obligation rests with medical educators to do everything possible to prepare their pupils, to the end that the effect upon the public will enhance the prestige of scientific medicine. The individual graduates owe it to their profession to give careful thought to this phase of their contact with the world.

Dr. John J. Abel says: "There should be in research work a cultural character, an artistic quality, elements that give to painting, music, and poetry their high place in the life of man." A fanciful way of putting it, but it conveys the idea I have in mind.

The people get their misinformation about scientific research in devious ways. Much of it is furnished by the anti-vivisectionists and the other antis. Just now a sensational novelist has furnished a good dose of it in "Arrowsmith." Thousands are reading it and thereby doubtless getting very fixed ideas of the unworthiness of scientists in general. In this novel all the characters who are credited as true scientists are given rather unpleasant personal attributes. Gottlieb has no heart or sympathy, his experimental controls must be carried out relentlessly, whether a number of human beings are sacrificed in the experiments or not. Sondelius has a heart, but he is a sort of roughneck, boisterous, drunken, and obscene. Martin Arrowsmith could have been handled more gently, but scenes of drunkenness and gambling are introduced to mar his good life work. Terry Wickett is cynical and grouchy.

On the other hand, all the characters in the novel, like Tubbs and Holabird, who are given credit for any refinement at all, are made fun of and depicted as nambypamby, pink tea scientists, using their positions for personal social advancement. One gets the impression that the collaborator of Sinclair Lewis, who furnished the medical stage business for the book, must be a misanthrope with an axe to grind because of experiences in the McGurk institutes of the country which have not been to his liking.

Garrison calls attention to the fact that the century which saw the beginning of scientific medicine "was the culmination of an age in which the Greeks reached a degree of civilization and a supremacy in

* Inaugural address as President California Medical Association, delivered at Yosemite, May 18, 1925.

EDWARD N. EWER
President C. M. A. 1925-1926

philosophy, lyric and dramatic poetry, sculpture and architecture, which has not been equaled by any people who came after them. Never before or since had so many men of genius, the contemporaries of Hippocrates, appeared in the same narrow limits of space and time. Hippocrates gave physicians the highest moral inspiration they have, and he crystallized loose knowledge into systematic science." Thus did a period, during which cultural knowledge reached its acme, bring about the very birth of scientific medicine, and provide it with a code of ethics, than which we have no better today.

Of course there has never been a time in history when medicine and medical men have been quite free from criticism, and their activities even caricatured. Perhaps our hypersensitiveness is bred of our irritation at the apparent lack of applause at the wonderful fruition of the years of *experimental science.* These years are few in number, compared with the centuries of study by *observation,* or as Claude Bernard called it, *passive science.*

In our strenuous efforts to bestow upon a more or less unwilling world the benefits of recent progress, we have interfered with the tranquillity of our smug parasites—those greedy pests that live on the fringe of decent medical society and at its expense. I refer to the myriad frauds which have wilted a little in the sunlight of our propaganda for reform. We cannot entirely destroy them. Each new discovery fertilizes them into rank new growth.

For instance, discovery of a few physiologically active glandular principles has stimulated the business of marketing, through medical channels, most of the messy stuff in the abattoirs, which people could not in any other way be persuaded to eat. These endocrine vendors mix up glands and their principles like Hungarian goulashes, make them into tablets, and men who have spent seven years in medical college are expected to fall for this shotgun endocrinology.

We have killed about half the patent medicine evil and have made enemies doing it. At first the periodical and daily press were none too pleased with the decline in patent medicine advertising; but later they rallied to the cause of honest medicine, and now make valuable allies.

We have valiantly fought the cults and quacks and have been roughed a little. They seem to thrive on opposition, and if we turn away the spot-light they will die out or grow into something useful and be absorbed, as have their long line of predecessors.

At present, there are under discussion two other subjects closely related to each other, as well as to the attitude of public criticism. One is specialism, and the other the failing supply of rural physicians. Both these matters rest upon the functioning of inexorable economic laws, which no sudden action by organized medicine, examining boards, or medical faculties can put aside.

The subject of specialism has been attacked by many writers during the last few years. It is curious to note that all straddled the question. They expressed a general feeling that there was something amiss, but none condemned the general practice of medicine, and none had the hardihood to condemn specialism as such. There was much concern over the relationship between the general practitioner and the specialist, and this was shown in the titles of many papers. There was comment upon the arrogant attitude of many specialists toward the family physician. The fact that such attitude exists at all may show the approach of the saturation point in specialism. If certain specialists find it necessary to argue specialism to their clientele and others in season and out, not sparing unworthy criticism of those who work in wider limits, the inference is they are feeling the pinch of hard times.

The advantages of specialization are stated by L. F. Barker to be: "It increases productivity; facilitates the acquisition of accuracy, speed and skill; provides for a better distribution of tasks; economizes material equipment and mental energy; and accelerates discovery and invention."

Specialism in medicine is only response to the spirit of the times. The public is familiar with it in commerce and industry, and undoubtedly encourages it in medicine. This encouragement meets ready answer in our ranks, where mental and physical capacity are subject to variations the same as they are in a Ford factory.

Ultra-specialism, however, is of questionable value. It prevailed in Egypt four hundred years before Christ, when Herodotus, the historian, says, "Each physician applies himself to one disease only, and not more. All places abound in physicians." And yet in ultra-specialism the individual of average ability and the genius, alike, seem at present to find

fertile soil. The one content to drive one bolt in the human flivver, day in and day out, gains a proficiency and prestige denied him in the broader field; and the other, of great mind, concentrating a lifetime upon one line of endeavor, should be expected in addition to material success, to add something of discovery and invention to the total of medical knowledge. If he does not reach these heights, he wastes his talents in narrow specialism, and his life would have been better spent in the service of broader practice.

To those who are inclined toward general practice the situation need not be wholly discouraging. The field is and always will be open in villages and towns; and in every great city are to be found men with enormous general practices doing the best of work. Their success is based upon that soundest of foundations—service. These men recognize the necessity of specialists. They use them freely when the welfare of a patient depends, first, upon the expert use of some instrument of precision too infrequently used to warrant inclusion in their armamentaria; second, upon the exercise of skill in technique, only to be gained by experience with many patients of a particular type; third, upon laboratory work too time-consuming for them to undertake. They choose their specialists with discrimination, for their ability and for their broad-minded willingness to co-operate, and who dare say the patients' interests are jeopardized by passing through the hands of such a general practitioner?

It has been said, "Patients who independently seek the aid of specialists often make a mistake, and the tendency is to be deprecated." With certain modifications this is true. A clientele, all his own, is a tempting asset to many specialists, but this does not alter the basic fact that a broad survey by a general diagnostician is, in most cases, of paramount value to the patient. The ability to make this survey should be the aim of the general man. Perhaps it will mean, especially in cities, his evolution into what we call an internist. The internist now is really a sort of advanced general practitioner. He is the diagnostician and distributor for the other specialties, like the family doctor, but he enjoys the prestige of specialism, and is most useful in his broad field. However, there are signs of disintegration here, for we see his work undergoing subdivision of the ultra-variety, to make room for the electrocardiographer, the gastrologist, the allergist, and, very lately, the periodic medical examiner. The latter is a new and perhaps logical development in the attempt to keep some place open for the wise individual who wants to know which specialist he needs, if any. Seriously, we do not know how far specialism is going, but we do know that in the reasonable subdivision of labor, energy is conserved. If it goes too far, integration will begin, and proceed until the economics of the situation are satisfied.

The same melting pot of economic laws figures in the problem of the distribution of physicians. This is the most actively discussed subject in medical economics today. The failing supply of physicians has caused great complaint from the residents of many rural districts, and there have been demands for drastic relief measures. One of these was a bill introduced in the Tennessee Legislature two years ago. It was entitled "The Abolishment of the Preliminary Board of Medical Examiners." This legislation was devised with the view of curtailing the length of time and expense required to get a medical license to practice; and its author believed its passage would cause more physicians to locate in the remote country districts. The bill passed both Houses, but failed to receive the Governor's signature. The same position is taken by Dr. Pusey, who believes that shortening the time spent in medical college would attract to medicine a type of individual who would be satisfied to take up the burden of country practice. If this were so, we ought to see the cultists avoiding the cities and flocking to the villages and cross-roads; but while short in knowledge, they are often long in business wisdom. The other side of the thesis is exhaustively treated by Mayers and Harrison in a report of The General Education Board in 1924.

There never has been great attraction in the hardships of country practice, and even twenty-five years ago many young graduates only took it up because of the crowded condition of the profession in the cities, and because of the common belief that a living could be gotten more quickly in the village communities. After a financial footing had been gained, and experience acquired, many left for the cities. After the war the movement was accelerated. Many medical officers recruited from the country never returned, as they had conceived new ambitions through experience in well-equipped hospitals, and through special training in army schools. Many of these entered the specialties of medicine, and have kept pace with their metropolitan confreres.

At the same time there has been a general movement, outside the profession, toward the centers of population. The farmer cannot keep his sons and daughters at home, and has trouble getting labor. Over 50 per cent of the country's total population is in towns of 2500 or more. From 1910 to 1920 the rural population increased only 3 per cent, while the urban population increased 26 per cent. This indicates where the work is, and there the physician will go. One author says: "The reasons why the country doctor will not stay in the country are these: the inadequate fees, the bad roads, the hard work, the lack of hospital accommodations, insufficient educational opportunities, but above all, the lack of loyalty on the part of his patients."

When trained statisticians and economists study the subject, the reason for the exodus of rural physicians becomes manifest. The following passages from Raymond Pearls' article are expressive: "It is apparent that generally the exodus in recent years of physicians from the rural locations has had associated with it a definite and marked decline in the per capital real value of farm property. In short, it is seen again that the behavior of the physician in the conduct of his affairs betokens a considerable degree of good economic sense. The physicians behave in the conduct of life about as any group of sensible people would be expected to. They do business where business is good and avoid places where it is bad."

"After a young medical man gets out in the

world and by hard experience learns economic wisdom, his behavior thereafter, relative to location, will not be different according to whether his education was expensive or cheap."

One of the conclusions of the General Education Board report is: "There is no validity in the view that the proportion of recent graduates settling in the rural locations is lower than the rural population has a right to expect." The Massachusetts Legislature ordered a report on rural health and medical service, and the Department of Public Health made a report in January of this year. Some of its findings are: "Unless the movement of the general population from the country to the city is checked, the economic factors will increase rather than decrease the inability of certain locations to support a physician. Less than 6000 of the population of Massachusetts is more than six miles from a physician. The physician's charge for a distant call, compared with garage charges for making the same trip, shows that the difference is less than the usual fee for the physician's house visit in his own village. This places no higher valuation on the time the physician spends on the road than if he were a taxi driver."

Many examples were found of lack of loyalty in supporting the local physician which was not based on his professional shortcomings. The farmer is not behind his city cousin in his belief in specialists, and he often drives thirty miles to the city for more expensive, but no better, advice than he could get at home. His faithful professional neighbor, good enough for the drudgery of night calls and emergencies. only gains his full confidence when he displays intelligence enough to go where the business is going.

It seems to me there is danger in this propaganda for lowering the standards of medical education. The alleged unfortunate plight of the rural dwellers makes good copy, and it is beginning to be exploited in the periodical literature. It is likely to have its effect upon state legislatures, already prone to dangerously weaken requirements for medical licensure.

Though the argument looked plausible at first, I have failed to find any data sponsored by trained investigators which affords proof that high standards of medical education are at all responsible for rural shortage of physicians.

A study of the exact situation in California, made by our own council or by the league, would be of value if the discussion becomes acute or menacing from the legislative standpoint. I believe such a survey would show conditions to be about as they are in Massachusetts.

In conclusion, it would seem that our public is critical, not because it fails to recognize the colossal advance in medical science, but because the upheaval has subtracted something from the sympathetic, personal contact, so satisfying in the past.

Attempts should be made to overcome this by bringing back into the education of the physician some of those subjects which were of old considered necessary in the equipment of the well-educated person, but which have been dropped as impractical in this business age. They have to do with what we call the art of medicine.

The education of the present fits the physician superlatively for his narrow specialty, but it is not education which commands instant and general recognition. He knows his own attainments and he puts a label on them: surgeon, internist, obstetrician, and he is recognized at his own appraisement, and that only. Most of those subtle influences which could bind him to the human interest activities, such as languages, history, art, music, poetry, and religions, are crowded out of the pre-medical years. Much of the great mass of technical detail which has taken their places is undigested, hence not available for the practical field worker, but most valuable to provide the necessary succession of research workers. The needs of these two classes—field worker and research worker—seem divergent, in that the fifty are being forced that the one may emerge in perfection. The fifty must deal with tried and proven methods for the cure of ills, and in addition must be made into attractive mold that public sentiment may be directed, and scientific medicine allure, not repel.

In spite of all, medical progress is unquestioned and unrivaled. As regards our relations with our disreputable camp followers, quacks, cultists, sellers of useless medicine, and the rest, we are warranted in feeling optimistic, and hope to be loved some day for these enemies we are making.

251 Moss Avenue.

Zinc Stearate Dusting Powders for Infants—The second report of the Committee on Accidents from Zinc Stearate Dusting Powders appointed by the Board of Trustees of the American Medical Association has recently been published. Copies of this report, with an appendix showing the opinions of thirty-four representative pediatricians on the therapeutic value of such powders, can be obtained on request. Address, Committee on Zinc Stearate Dusting Powders, American Medical Association, 535 North Dearborn street, Chicago, Illinois, enclosing a self-addressed, stamped envelope. There were reported to the Committee 131 accidents from the inspiration of zinc stearate dusting powders by infants. Twenty-eight of the victims died. The Committee conferred with representatives of certain distributors concerning the dangers incident to the use of such powders on infants. Following a meeting held at the headquarters of the American Medical Association, these distributors agreed to co-operate by adopting self-closing containers for the powders they distribute and agreed that cautionary labels are desirable. Opinions were secured from thirty-four representative pediatricians concerning the therapeutic value of zinc stearate dusting powders. Thirty-one believe that such powders have no advantage over other dusting powders, that they constitute a hazard to infant life, and that their use should be discouraged.

Pathology of the Hypophysis—It is evident from the seven cases reported by J. P. Simonds and W. W. Brandes, Chicago (Journal A. M. A.), that, with advancing age, in many persons the hypophysis undergoes fibrosis, and the body does not receive the normal amount of the secretion of this gland. Fibrosis of the anterior lobe of the hypophysis occurs with moderate frequency in persons past 50. This condition is apparently due to arteriosclerosis of the vessels of the hypophysis. The character of the lesion is such that it must interfere with the function of the glandular portion of this organ. This suggests one of the reasons for the failure of efforts at rejuvenation that are directed to the restoration of only one gland of internal secretion. One case of the series here reported appears to be true chronic hypophysitis. In spite of the negative Wassermann test, other findings in the body suggest the possibility of syphilis as its cause.

A GENERAL CONSIDERATION OF SUSCEPTIBILITY TO SKIN DISEASES *

By GEORGE D. CULVER, M. D., *San Francisco*

It rests upon the shoulders of the dermatologist to go more than skin-deep. Careful advice as to exercise, rest and proper eating will greatly improve oxygenation, raise the skin resistance, and often mean the deciding point between success and failure in the practice of this specialty.

WITH the large proportionate increase in infective skin eruptions and with recent added interest in occupational dermatoses, a vital question again and again arises as to how great a factor is the lowered individual resistance, permitting what would seem to be a fairly definite individual selection. The same question has to be considered in reference to many of the skin disorders.

If the presence of the streptococcus were all that is required to give rise to the numerous instances of streptodermatitis, we should all have some form of streptococcic infection. We must assume that the sufferer has a lowered resistance or has something within his skin that makes of it a suitable soil for the rapid multiplication of streptococci. The eruption might indicate the presence of the organism in the lesion, or it might be an evidence of the toxic effects of its products. It would still mean something inherently wrong with the individual skin. This should hold true with most, if not all, eruptions caused by micro-organisms.

Furthermore, it isn't unreasonable to believe that something more than simple idiosyncrasy and natural susceptibility enters into dermatoses produced by external irritants. For example, many an individual may have worked at his occupation for years, and suddenly he becomes sensitive to something he is using, as a painter with his turpentine. It is occupational, yes, and seriously so, but it doesn't always mean that he must quit painting. Not infrequently there are other reasons than the known one for his hypersusceptibility. It is up to us, as dermatologists, to ferret out and correct such other faults as may be at the bottom of his recently developed susceptibility.

For a long time I have been attempting satisfactorily to solve some of the questions arising in many instances of eruptions easily diagnosed, but not always so easily eradicated, constantly striving toward more effective treatment, and also toward greater security in prophylaxis. Any evidence I may offer is so inconclusive that it is tendered only along the line of a suggestion to stimulate further observation.

Dermatology as a specialty, equal in importance to any branch of medicine, can hold its place and grow only as the dermatologist fulfills his mission of successfully treating his patient, not alone his patient's disease, and to do this he must have a clear conception of all the factors involved. It is my belief that a furuncle or carbuncle surgically treated, however skillfully, but with indifferent care given the patient himself, is neglectful ministration. Much dependence is naturally placed upon the inherent tendency for the human body to recover, and many an opportunity is lost when that tendency is not stimulated through proper direction in fortifying the patient's resistance to the particular disturbing element which may be specifically responsible for his disease.

It is this defective resistance that should be of such great interest to the dermatologist, and the neglect of which we all at times are guilty. Most satisfactory results often occur in stubborn skin eruptions, resistant to ordinary treatment, when a normal dermal physiology is brought about.

A certain proportion of the patients we see are either free from organic defects or are suffering little because of them if present, whereas but few are free from functional disorders. How necessary it is to recognize those functional disorders and to be able to so direct the patient as to correct them.

Consider, for example, the epidermophyton implantations which, with other fungus disorders, are increasingly numerous, making of every swimming tank a danger spot. And yet not everyone exposed is infected. Again, we may ask the question, Why? No doubt a disturbed physiology is frequently, if not always an important factor. If largely dependent upon an hyperidrotic base the factor may or may not be easily controlled, but it would seem to be our duty to make the effort, in justice to the one seeking advice to avoid subsequent reinfection. I have seen most dramatic changes take place in that tragic state of wet, putrid feet when excesses of eating, especially of the rich carbohydrates, were properly regulated and other faulty habits corrected. I am not contending that it is just a food question, but it must be admitted that in many instances of both acute and chronic skin affections there is something basically wrong with the skin activity, and what more likely than that it should be influenced by daily regime, including faulty dietary, neglect of exercise and irregular or insufficient rest, all of which may affect the body covering, as well as other parts, especially insofar as skin nutrition and oxygenation are concerned.

Examples innumerable, explanatory of my contention, may be cited, but they would be tiresome. I shall give only a few recent ones that were of particular interest to me.

A physician under 35 years of age came to me nearly a year ago with what was clinically an infective dermatitis, involving the face, neck, and arms to such an extent that he could not satisfactorily practice his profession. He had gone through a most careful series of tests for some specific element that might be the cause, and, though he reacted to a number of things, the blame couldn't be laid to any one. He suffered for two years. After treating him several months unsuccessfully he became discouraged and so did I. It fell to me again to attempt to advise him, and we started anew, just as if he were a patient for the first time. He was asked to follow a much more rigid daily routine of exercise, regular and sufficient rest, with carefully regulated meals. Internal medication was directed toward normal elimination, proper alkalinization and improvement

* Chairman's Address, California Medical Association's Section on Dermatology and Syphilology, delivered at the 1925 Session in Yosemite, May, 1925.

in his general well-being. Within two months his skin was clear, and it remains so, but on the least provocation gives evidence that it is ready to again flare up. It was neither the arsenic nor the iron given him that caused the disappearance of the trouble—which also failed to be influenced by endocrine medication, vaccines, or x-ray. Recovery was probably due to systemic improvement through better general body tone and better physiological functioning of the skin, with a consequent raising of its resistance. This man had asthma, and this symptom also has disappeared.

In an instance of severe streptodermatitis of the legs, which hospitalized the patient for the greater part of four years following the war, the condition entirely disappeared under careful routine directed toward raising the patient's general resistance, and simultaneously the resistance of his skin to the infection.

A young woman with recurrent generalized dermatitis, clinically of an infective character, who had been inadvertently treated for poison oak by many methods, gave evidence of harboring the streptococcus in her throat. Treatment for focal infection alone and symptomatic treatment of the skin proved quite discouraging. Not until the patient herself was considered of prime importance and treated accordingly was real success attained.

Because it is possible to do so much with the skin with the many varied and remarkable agents now at one's disposal to either cure or eradicate so many manifestations of skin disorders, and because the task of treating the patient is so difficult and so laborious, the tendency is surely toward a greater perfection of the former agents and methods, to the neglect of the latter important phase of the question under consideration.

I am not scolding the other fellow; rather my inclination is to chide myself for so frequently drifting into the easy way of treating the disease instead of the patient. Should a patient come to me with that most trying condition, acne rosacea, there is no hesitancy on my part as to what I must do, for I know that by treating the facial manifestation alone I shall partly or completely fail, and certainly not make the patient's future sufficiently secure, whereas by treating and directing him generally as well, the chances of success are greatly multiplied. My neglect in one instance was firmly impressed upon me by the patient himself, a friend suffering from psoriasis, whom I treated perfunctorily for his "spots," as did others of my confreres. About a year ago he developed a marked rosacea, which stimulated me to more carefully consider his condition. Under more careful treatment his rosacea disappeared, a glycosuria disappeared, and his psoriasis has become much more manageable. What a growing tendency we have to treat acne topically only, because of having such an excellent help as the x-ray. However, we owe it to the patient to do as much for him otherwise as he is willing to accept.

Within the last month a man 32 years of age consulted me for a recurrent infection in the right scrotal-thigh fold, covering a period of one and one-half years, involving part of the time the scrotum and part of the time the skin of the thigh. There were abscesses and numerous ulcerations. He presented a marked acne rosacea of the middle portion of the face, gave a history and showed the scarring of an extensive acne of the back which had been present when he was then years younger, and the back of his neck was almost covered with scar tissue. This man for ten years had been treated while in college, later while in the army, and many times since, always locally alone, for the particular condition present at the time. It is quite evident that this patient was in need of a most rigid and systematic routine with the proper tonic and regulating medication to build up his resistance, which in the past had been improved only insofar as his natural tendency to recover counted, and as he grew older this resistance lessened rather than increased.

I am of the opinion that some of the endocrine instability which we find favoring skin changes, and much of that which we conjecture as a possibility, would be lessened or completely removed under improvement in the general well-being of the patient.

Since such a large part of a dermatological practice is made up of those not acutely ill and of those apparently able to work, the physician is inclined to pass lightly over skin eruptions and to send referred patients back with negative findings. Not infrequently those are just the ones that continue to have their skin annoyances until the basic functional disturbances are corrected.

It, therefore, rests upon the shoulders of the dermatologist to go more than skin-deep. Careful advice as to exercise, rest, and proper eating, will greatly improve oxygenation, raise the skin resistance, and often mean the deciding point between success and failure.

323 Geary Street.

Blood Pressure Changes Accompanying Coronary Occlusion—In the absence of hemorrhage, shock, infectious disease and excessive toxic or metabolic disturbance, such as diabetic coma, and with the presence or history of severe pain of cardiac origin or distribution, Leslie T. Gager, New York (Journal A. M. A., June 6, 1925), says that the fall in arterial tension will commonly be due to acute myocardial insufficiency on the basis of coronary occlusion. Four cases are cited to show the value of a series of blood pressure readings, when coronary thrombosis is in question. Gager further says that: The recognition of a sudden fall in blood pressure, following an attack of severe cardiac pain, derives its importance from the fact that coronary occlusion brings about this state of hypotension by striking directly at the cardiac output. Following the thrombus formation, or the lodgment in an embolus, in a coronary artery, there occur (1) infarction of the heart muscle to a degree corresponding with the site of obstruction, and (2) impairment or loss of ventricular function according to the area and extent of the infarction. Since the left coronary artery, or its branches, is commonly involved, it is usually the greater circulation that offers the evidence of cardiac failure. In the milder instances of occlusion, or in cases in which the left ventricle escapes, little or no variation in peripheral arterial tension may occur. It is Gager's contention, however, that blood pressure readings, taken daily or even oftener, form an important detail in establishing the diagnosis of coronary occlusion. It is a method of observation at the command of every practitioner. A sudden fall in arterial tension, following severe cardiac pain, rests on the physiologic basis of infarction and myocardial insufficiency following an occlusion.

UNUSUAL UROLOGICAL LESIONS *

By FRANK S. DILLINGHAM, M. D., *Los Angeles*

Brief reports of three cases of fracture of the penis, one of priapism, one of anaphylaxis, and four of toxins from ascarides and oxyuris, causing hematuria and albuminuria.

FROM time to time we all see interesting and, sometimes, rare conditions which, through lack of time or inclination, are not reported to our local sections, or perhaps because of a feeling that the report would not interest a group of men practicing the same specialty; yet if briefly reported such rarities might call forth reports of similar conditions by others, and the discussion might bring out some practical points of benefit to all.

To successfully practice urology, it is necessary to have a broad knowledge of all the specialties. The increasing knowledge of anaphylaxis, referred pain and focal infections, have played their part in forcing us to look beyond our own field in arriving at a final diagnosis.

Last year we were told of a large railroad hospital in which every patient with abdominal symptoms was studied by the urologist before being subjected to laparotomy, with the result that there have been less abdominal operations, and the proper treatment of unsuspected urological conditions have permanently cured the patient.

As our program is very full, I will briefly report a few histories, and wish to add a case of priapism to those reported by two of our members, Doctors Player and Kutzmann, in the Urologic and Cutaneous Review, December, 1923.

Patients with arthritis are sent to us for study, and it is hard and sometimes impossible to give their physician a definite answer as to whether the urological tract may be at fault in the presence of a small soft prostate, with moderate infection in the prostate and vesicles, when there may be associated in the same patient beginning flat-feet, infections in tonsils, teeth, or elsewhere. An orthopedic surgeon referred a patient to me who had arthritis of the right hip which had progressed so far that they had to apply a Bradford traction and abduction brace and arch supports. This patient had been thoroughly studied and no foci found in the teeth, tonsils, intestinal tract, or elsewhere. His prostate was small and only slightly infected, and in my opinion was not likely to be the source of the patient's trouble, but as the usual foci were reported negative a thorough course of massage of the prostate, with stripping of the vesicles, followed by an antiseptic, was instituted and he fortunately responded at once. The patient is back at work as a cutter in a tailor shop, where his occupation compels him to stand all day. He has not had to wear the brace nor plaster cast since last November, but continues with his arch supports; he has no pain.

A woman, aged 39, complained of a burning pain in the urethra, was cystoscoped and carefully examined, but no cause could be found, and as a last resort skin tests were made and she was found to react strongly to coffee and eggs. As long as eggs in any form and coffee were omitted, she had no pain. Local applications of silver nitrate were made to the urethra and bladder neck, and at the end of a year she could gradually return to both coffee and eggs.

Several years ago a 5-year-old child was examined who had a history of hematuria and frequent painful micturition over a period of three weeks. The parents were alarmed and feared Bright's disease, as they could see blood and had been told the urine was loaded with albumin. Pinworms were discovered and their removal caused the bladder symptoms to abate, and the cystitis was cured in a week's time, with no return of symptoms, and the urine has remained free from blood.

Two years ago, in consultation at the hospital, I saw another patient with a heavy ring of albumin who was supposed to have Bright's disease. I was fortunate enough to enter his room as the nurse had finished giving an enema, and several round worms had just been washed out. Appropriate treatment of this condition cured the albuminuria. Last year another patient who had been in the hands of good physicians in Denver and Los Angeles, who had been cystoscoped and carefully examined to determine the cause of pain and throbbing in the urethra, and who received no benefit from treatment through the endoscope with silver, was found to have round worms, and treatment of this condition promptly relieved the reflex symptoms in the urethra.

A tape worm in a woman of 35 caused albuminuria and a dull ache in the kidney regions which was relieved as soon as the tape worm was removed.

Doctor Arthur Herrmann was kind enough to go over some of his histories for me and found three reports of worms in the bowels, causing frequent micturition, vesical tenesmus, blood and albumin in the urine, which were relieved in each instance as soon as the worms were removed.

"A girl, aged 7, had been suffering from digestive troubles and vesical tenesmus for several weeks; was taken suddenly ill with a slight convulsion. She had recovered from the convulsion before my arrival, was slightly delirious, and the temperature was 104. Urine examination showed albumin, microscopic blood, no pus or casts. There was no swelling of the extremities. A careful history elicited the fact that the child had passed some round worms and also pinworms a few weeks previously. The administration of santonin and quassia injections, together with a clove of garlic daily, gave prompt relief of all abnormal symptoms.

I was called in consultation to see a boy aged 3 in a severe convulsion which was abated with chloroform. He had been a vigorous child, but lately had become fretful, complained of abdominal pains and loss of appetite. There was frequent micturition, he wet the bed, was restless in his sleep, and lost weight. Urine examination showed albumin, blood, no casts or any abnormal findings. A close questioning of the mother brought out the fact that the child had passed some round worms a number of weeks

* Chairman's Address, California Medical Association's Section on Urology, delivered at the 1925 Session in Yosemite, May, 1925.

previously, and that she had given him some worm candy which caused the expulsion of several. The usual treatment by santonin was instituted and a large number of round worms were expelled; the urinary and all other disturbances were immediately relieved.

A girl, aged 4, was brought to the hospital, having been referred to me by the late L. M. Ryan, with a diagnosis of pyelitis. The chief complaint was frequent micturition, bladder tenesmus, loss of weight, and irregularly elevated temperature. Urine examination demonstrated B. coli, pus, blood, and albumin. There was intense itching of the anus and genitalia. She had been given the usual alkaline and urinary antiseptics which gave intermittent relief. The history demonstrated she had been troubled with pinworms irregularly for more than a year, to which the mother attached no significance. The child was placed at an angle of 45 degrees for twenty minutes, and once daily a solution of quassia bark was allowed to flow in the bowel. A clove of garlic was given in her food once or twice daily. The alkaline treatment was continued for the pyelitis and after several weeks the child slowly recovered, while the tenesmus, pruritus and excoriated genitalia cleared up within a week.

CONCLUSION

The chief interest in the study of these cases is the fact that the toxemia and urinary symptoms cleared up on the expulsion of the worms; that the toxic substances produced a renal irritation due to some secretion from these worms, that they cause a mechanical irritation which gives reflex symptoms to the urinary tract, adjacent tissues and cerebral cortex."

A patient with typical renal colic, whose x-ray plate showed an oval shadow in the region of the right ureter, could not be cystoscoped because he had filiform strictures. These strictures were dilated as rapidly as possible with a fairly prompt and progressive improvement in his renal symptoms, and when a shadow catheter was passed to the pelvis of the right kidney, the shadow proved to be a lymph gland, and this patient has had no more renal symptoms.

THREE CASES OF FRACTURE OF THE PENIS

A laborer, aged 28, said he turned over in bed while he had a partial erection. The rupture occurred at 5 o'clock in the morning and caused considerable pain, but he went to work. I did not see him until 5 o'clock that afternoon. The skin was edematous, infiltrated with blood from the root to the glans, and a distinct tear of the right corpus cavernosum was found .025 long. The clots were (2.5 cm.) turned out, hemorrhage arrested, fascia lightly sutured, four linear incisions the full length of the shaft were made through the skin on account of the excessive edema, and the organ carefully bandaged. The wounds healed by first intention, and the man made a perfect recovery, with no deformity.

A doctor about 30 years of age sustained a similar injury while climbing out past the steering wheel of his car. He was seen within an hour. With careful bandaging and rest in bed, the clots were absorbed and there was no deformity.

A cowboy was similarly injured by being thrown on the pommel of his saddle. By using about a 20 gauge needle, we were able to aspirate the clotted blood enough to relieve his condition. This was followed by bandaging and rest in bed, and he was able to return to work in a week or ten days.

Priapism—During the late war a certain patient was gassed three times, which caused him to lose considerable weight. Throughout the war had chronic dysentery, and upon returning home an infected appendix and gall-bladder were added to his troubles. On March 20, 1922, the patient had a constipated passage which was immediately followed by pain in the perineum, to relieve which he made pressure over the perineum. This in turn was followed by a full erection, which was not relieved by hot or cold compresses, morphine or several other measures, and lasted for three weeks, at which time the erection gradually subsided. Full doses of epsom salts gave the most relief. When I saw the patient in consultation he was well nourished and has scar from his former appendectomy and cholecystectomy. General examination negative, with the exception of infected teeth and tonsils. Denies ever having had any venereal disease, and blood Wassermann was negative. Eyes and reflexes normal. No nasal polypi; no enlargement of the prostate gland, but the hemorrhoidal veins were engorged. Urination difficult, but not painful. Patient complained of being tired, even to exhaustion, partly from loss of sleep and partly from nagging pain in the penis and the anal regions.

The penis was erect, engorged, harder and larger than normal, the corpus spongiosum being involved, as well as the cavernosa. The testicles were normal, and the urine negative. There was no sexual desire; intercourse tried once, but was painful and afforded no relief and was not repeated.

I recommended that the teeth and tonsils have immediate attention. This was not done, and later, in connection with doctors of the Public Health Service, I saw the same patient suffering with a severe purpura hemorrhagica, and again recommended that the teeth and tonsils have immediate attention, beginning with the teeth. Upon examination, eleven teeth were found to be infected. These were removed one at a time, each extraction being followed by considerable general reaction, but this treatment eventually cured his skin condition.

As a result of the priapism, the patient has a loss of erectile power amounting to fully twenty-five per cent. He is still forced to wear elastic stockings on account of the edema in his legs, and is not able to work. Cause of his trouble is considered to be due to thrombosis, probably resulting from infection from the teeth and possibly tonsils.

Drainage of the corpora cavernosa in this case would probably have afforded immediate relief and would not have been followed by as much loss of erectile power.

548 South Spring Street.

SOCIAL ASPECTS OF THE FREE DISPENSARY *

By Robert Ewart Ramsay, M. D., *Pasadena*

The free dispensary, as a philanthropic institution, can not do otherwise than divide the applicants into two classes—those who can be freely treated, and those who cannot be treated at all.

Once the Social Service Department has ascertained the social status of the patients who wish to pay a small fee, and determines that they are worthy of some fee deduction, it can find physicians who are willing to handle these part-pay patients on a part-pay basis, without detriment to their established schedule.

There is none of us who will not co-operate in that wise philanthropy which increases self-respect and conduces to self-support. But undeserved charity breeds selfishness and pauperism in the recipient and wearies and disillusions the philanthropic worker.

THE free dispensary exists to give aid to persons who are not able to pay the customary medical fees. Philanthropic individuals and associations give their means, volunteer workers give their time, and physicians give their professional advice and service. Superintendents, nurses, social workers, secretaries, clerks, and volunteers give very often more than the time of the working day. To all of these, but especially to the donors, the volunteers, and the physicians, it is a matter of great concern to know that the service they so freely give is bestowed upon persons who are needy and deserving. Physicians are especially concerned because it is manifestly unfair to be called upon to give advice without charge to persons who are able to pay.

The practical problem of deciding who are deserving of help is not difficult. Slipshod methods of administration have made it appear so, and sentimental considerations have undermined the morale and the efficiency of many a philanthropic institution. The public has little respect for organizations so easily imposed upon. Those who are helped call themselves clever in getting for nothing what others must buy, while the workers develop contempt for certain of their beneficiaries, or take the matter into their own hands by making unkind remarks or giving a lower type of service. If the problem is not faced squarely and decided on business principles, the right kind of work is not done.

Consideration of the actual conditions which arise in the conduct of a free dispensary will disclose the nature of the problem and show how it may be approached. For this reason I have reviewed the social records of 1384 consecutive admissions to the free dispensary of the Anita M. Baldwin Hospital for Babies, children's department of the California Lutheran Hospital of Los Angeles. The facts in these records were verified by home visits in practically all of these cases, the exceptions being those in urgent need and families manifestly large in numbers. I have also reviewed the records of 398 consecutive applicants who were referred to private physicians because, by their own admission, they were financially able to pay. Unfortunately, for the purpose of statistical comparison, this number does not represent the total number of persons who visited the dispensary and were discouraged from entering, but only those who went far enough to have an interview with the social service department, with the end in view of establishing a satisfactory social status.

All applicants have been questioned on the day of admission with regard to sources of income, amount of average income by the week or month, regularity of employment of the wage-earner, number of children in the family, number of other dependents, and in the case of a woman who supports her family, as to whether she is divorced, deserted, or a widow. This interview is resented only by those who have come to the dispensary under a misunderstanding or with the thought of taking advantage of its charitable purpose. The social visit which is made to confirm the impression at the interview is never resented by the *deserving* families. Rather is it welcomed because, when they have told their story and welcomed the representative of the dispensary in their homes, they feel established in friendly confidence, entitled to aid, and free to seek from nurses and doctors solution of their various problems. The procedure is of great value in cases where families are staggering under burdens too great to be borne and there is help from other agencies than our own which can be mobilized in their behalf. Our own work depends so greatly on home conditions that the need for this friendly co-operation with the home is self-evident.

Subject to modification by extenuating circumstances, we have adopted an arbitrary standard of $120 monthly income for a family of father, mother, and two children, making an allowance of $10 monthly for each additional child or dependent. This figure has worked out well in practice. It is sufficiently low to indicate that we demand some evidence of thrift. It is sufficiently high to indicate that we do not expect abject poverty before we give our help. The time to give the help that counts is when people still retain their ideals and have not given up their ambitions for themselves or their children, in time of temporary embarrassment, or in cases of large families. Into our special problem, as we see it in Los Angeles, enters the frequent occurrence of the family which has come to this land of promise, exhausted its resources before getting fully established, and finds itself unable to afford accustomed comforts. This type of family is worthy of our best help and sympathy.

Large families are a factor in bringing patients to the clinic. The average family numbered between four and five members, the exact figure being 4.41. The results may be summarized in a more effective way as 575 families of three or less, and 909 of four or more. Simple increase in numbers must mean either a decline in the condition of living, or a dependence on friendly assistance, or an unusual exhibition of industry and thrift. Thus, we found one family of eight living in apparent comfort and even paying on a home on a budget of $150 a month. Two families of fifteen members were found in clean and well-furnished homes. But, on the whole, simple increase in numbers, without the addition of unusual misfortune, is a factor in making friendly aid necessary.

* Chairman's Address, California Medical Association's Section on Pediatrics, delivered at the 1925 Session in Yosemite, May, 1925.

The care and illness of dependents is also a factor. When parents and children are just getting along, and an aged grandparent becomes ill, the family resources are strained to the breaking point. In twenty-two cases where families were living in their own homes, unusual circumstances, such as illness of the breadwinner or dependents, justified our extending aid. The same may be said of sixty-one families who were buying homes. In such cases, the families had cut down their margin to the quick in order to get their feet under them, and unexpected illness or lack of work found them temporarily bankrupt.

At times there appears in the clinic some person with furs, silks or jewels, disturbing to the morale of the whole establishment, the patients as well as the staff. Sometimes the disturbing person is not the parent, but some friend, neighbor or other philanthropic person who does not dress in a manner befitting her mission. Sometimes the finery is borrowed to bolster up the pride of the wearer who is making her first visit to a dispensary. It would be too easy to turn away the well-dressed and admit those who were poorly dressed. This is a method too commonly used in free dispensaries. It should be summarily condemned as a method which is inefficient and often unjust. Many who dress plainly are well able to pay, while others come in mistaken pride with all they have on their backs. A good social service department will use the best judgment possible at the time of admission and verify this impression by a visit to the home. Meanwhile, the workers knowing that they are being protected from exploitation, can be gentle in their criticism, and proceed with their work.

The automobile still spells luxury to our minds, and we become critical when we see patients arriving in cars. But much depends on the type of car and whether it is the property of the patient or belongs to a friend or neighbor who is helping out. Then, too, an automobile is a necessity to many kinds of workmen and tradesmen. Where the social service department finds that the automobile is of the type used for business and is owned and used for that purpose, we are charitable in our conclusions. When a family admits that paying for a touring car has diminished their ready money, we do not feel at all charitable.

A problem which frequently arises is that of the parent who comes to the clinic because she feels that she can get there the expert attention to which she has become accustomed but cannot now afford, and frankly explains that she can pay something and would prefer to be on that footing. To this admirable type of person it is not easy to give a rebuff, but the free dispensary, as a philanthropic institution, cannot do otherwise than divide the applicants into two classes—those who can be freely treated, and those who cannot be treated at all. It seems to me that once the social service department has ascertained the social status of the patients who wish to pay a small fee and determines that they are worthy of some fee deduction, it can find physicians who are willing to handle these part-pay patients on a part-pay basis, without detriment to their established schedule.

A periodic review of social status is necessary in order to exclude those who, because of increased prosperity, have become able to care for themselves. This is accomplished in simple fashion by requiring patients to register anew every three months. This necessitates another interview with the social service department and a new establishment of status.

A review of the cases which were referred to private physicians shows that the dispensary must have an alert social service department to inform applicants with regard to the requirements for admission. Let us put it this way, rather than to speak of exclusion, for many people come to the dispensary because they do not know a better place to which to go, to get the type of service which they desire. There is considerable satisfaction in giving these people courteous treatment. If they are newcomers to this region and have no physician, they may be given a list of the attending staff from whom to choose one. Some persons are shocked by the necessity for social investigation, because they have confused public health activity and private philanthropy. There is some reason for their embarrassment because national, state, county and city health agencies which are striving to disseminate information, and so far as possible to give practical help by means of health centers, baby welfare conferences, and the like, do not and perhaps cannot do otherwise than to serve all who care to come. It is not difficult, however, to make applicants see the difference between a public enterprise and a private one. Especially is it easy for them to understand that physicians who give their time freely must be assured that they are not being victimized.

The 398 cases which were given a social service examination and refused admittance represent that portion of those who applied for admission who were not satisfied with the information given at the desk nor self-condemned by a comparison of their income and the purpose of the dispensary, and therefore put their case up to the management of the dispensary. Ninety-six of these had a monthly budget of $150 or less which made them border-line cases, according to the number of children and dependents. Among the remaining 302 we found electrical engineers, school teachers, draftsmen, carpenters, bookkeepers, earning $200 a month; salesmen, insurance agents and small business men clearing $250 to $300 a month; an oil-well driller making $400 a month; a real estate agent who acknowledged $500 a month; and a dentist admitting $600 a month. Such cases illustrate the necessity for an efficient social service department. There is none of us who will not co-operate in that wise philanthropy which increases self-respect and conduces to self-support. But undeserved charity breeds selfishness and pauperism in the recipient and wearies and disillusions the philanthropic worker.

In conclusion, we may say that the majority of the applicants for the services of our free dispensary are worthy of our aid. There is, however, a large number of applicants who are perfectly capable of paying their way, have no business in a free dispensary, and should be excluded. This can be officially done by the social service department after conference, followed by visitation.

65 North Madison Avenue.

TEAM WORK *

By ROBERT BURROWS, M. D., *San Francisco*

ALTHOUGH efforts to alleviate pain during surgical procedure were practiced from time immemorial, it was not until the time of Morton in 1846 that practical anesthesia became a reality. However vague and uncertain the efforts before that time, there is no doubt about the truly wonderful development of anesthesiology since Morton's previous work. Much further progress may be confidently predicted. The list of scientific investigators, chemists, inventors and pysicians who have and are devoting their time and efforts to the development of better anesthesia is a long one. Along with progress in methods of eliminating or alleviating pain during surgical procedure has gone the marvelous development of modern surgery. Better anesthesia makes better surgery possible. The dangers attending surgery and anesthesia have been recognized and much has been done to overcome them, and work still goes on to lessen and avoid those that still seem unavoidable. It should be a matter of congratulation that the necessity of education in anesthesiology has been recognized and that courses are now included in most of our medical curricula. Education in this branch of medicine is as necessary and important as in any other, and unless we can appreciate the co-relation of anesthesia with other branches of medicine, our work becomes purely mechanical. The anesthetist must be trained as well as the surgeon, and by the proper training and co-ordination of their efforts good team work may be achieved.

The anesthetist should be much more than simply the one who administers a certain chosen anesthetic. His knowledge of medicine should be such that he would be considered a consultant before, during and after the operation. He should be able to evaluate the physical signs and symptoms, the laboratory findings, etc., so as to form an accurate opinion as to the patient's ability to take an anesthetic and the anesthetic required. It is the anesthetist who watches the general condition of the patient throughout the operation, and by the intelligent estimation of the condition institutes such remedial measures as may be necessary. That he must possess mechanical perfection in administration goes almost without saying, and in this connection we may well be grateful to those within our ranks who have devised mechanical means for the administration of anesthetics with certainty and precision, and these we should be familiar with, never forgetting, however, that a machine is still a machine and that the patient's condition is the final criterion as to whether the anesthetic is being delivered properly. Mechanical perfection is not enough. We must co-ordinate the mechanical part of administration with the known pharmaco-physiological reactions of the anesthetic. All patients are not alike, and we must be able to vary our agents, sequences, mixtures, and amounts according to the individual requirement. Also we should be sufficiently conversant with surgical technique to be able to follow the operation and realize the reaction of certain procedures. We cannot always anticipate the next step, and a word from the surgeon is invariably an aid. Our interest in the patient does not stop with the closing of the wound and the withdrawal of the anesthetic. Having watched the patient as to his condition throughout the operation, we should be able to advise as to post-operative measures, which may be necessary.

I wonder if we are always able to get the patient's viewpoint. We, working in and familiar with hospital atmosphere, may find it difficult to realize the impressions an individual may receive amid these unfamiliar surroundings, not always the most reassuring to the lay mind. Sometimes in our hurry we seem to forget the individuality of the patient and the various factors that may increase his nervous tension, and, all on edge, he is more or less hurried into unconsciousness amid strange sounds and conversation that are anything but soothing.

Do we not lose a great deal in attempts to hurry? During a crowded day, the temptation to do so is almost irresistible. Speed is a requisite in the successful carrying out of our work, and is only retarded by hurry. For instance, it does no good to hurry a patient to the operating room and then have him wait fifteen or twenty minutes before the anesthetic is begun. It does no good to hurry the anesthetic, though the combination of a refractory patient and a rushed impatient surgeon will sometimes make one try it, always to one's regret. It takes about so long to obtain surgical anesthesia, and when we try to rush it we usually find we haven't saved time, but have overdosed the patient. The use of local anesthesia by modern technique and the use of nitrous oxide, either alone or in combination, have shown us the advantages of gentle and unhurried manipulations. We have found, too, that with the more potent anesthetics that a little patience and gentleness will let us obtain the necessary relaxation without unduly saturating the patient.

In all instances proper pre-operative preparation of the patient should be insisted upon. There should be a complete physical examination and urinalysis. Too often we guess the kidneys are normal. Blood examination and blood pressure give us valuable aid in estimating the patient's condition. The advisability of using a preliminary narcotic is still perhaps somewhat of a moot subject, though most of us use one, believing that its advantages far outweigh its disadvantages.

It should be seen to that the patient is adequately protected from cold at all times, most especially during and after the operation. The position of the patient deserves more importance than it usually receives. Slight and simple adjustments can easily make it one of ease to the patient then and after, and by taking the muscles off the stretch, aid greatly in obtaining relaxation.

It should be seen to that our anesthetic apparatus is in perfect order with an adequate supply of anesthetic, and that whatever may be needful is at our finger-tips. Also that the means of stimulation or resuscitation are ready for use at all times and may be applied with the least confusion and delay.

Much in the way of preparation, examination, and various procedures for the patient's safety and com-

* Chairman's Address, Section on Anesthesiology.

fort seem most of the time to be rather small points, but if one of them is omitted at the wrong time the consequences may loom extraordinarily large.

Much benefit is to be gained by conference with the surgeon as to the progress of the case, noting the effect of the anesthetic after the operation as well as during it.

I have tried briefly to indicate various points whereby the anesthetist may co-ordinate his efforts with those of the surgeon, to the end that the patient may more certainly recover. By education, training, and a broader conception of anesthesia we become as skillful in our specialty as the surgeon is in his. Our knowledge of the subject must be that of a physician. It must be recognized that there is a close relationship between anesthesia and surgical procedure. Surgery is a therapeutic measure, done not for the sake of doing an operation, but in the interest of the patient's health. We work with the surgeon, sharing the responsibilities and co-operating with him, to the end that his success in getting the patient well may be assured. Our attempt is to render a service to both patient and surgeon in administering an anesthetic as skillfully and safely as our present knowledge and equipment will permit, co-ordinating our efforts with his toward the recovery of the patient.

2305 Sacramento Street.

More About Tryparsamide in Neurosyphilis—John H. Stokes and Louis F. X. Wilhelm (Archives of Dermatology and Syphilology, May, 1925), after an exhaustive discussion of the benefits and dangers from the use of tryparsamide in combating the most damaging enemy to human health, arrive at the following conclusions among others: 5. "Tryparsamide treatment is superior to other forms of treatment for neurosyphilis on the score of minimal expense, inconvenience and loss of time, and maximal symptomatic gain in mental cases." 6. "Eye complications constitute a definite risk, of which patient and physician should be fully aware. An examination of the eyes by a competent ophthalmologist, with special reference to visual acuity and perimetric fields, must precede the first administration of the drug, and be repeated several times, especially during the first injections of the first course, when complications seem most likely to arise." 10. "Tryparsamide produces a definite Herxheimer-like flare-up of symptoms in mental cases which must be allowed for in making plans for treatment, and may necessitate temporary custodial care of the patient with special nursing, restraint, and precautions against violence and self-injury." 11. "The social values in a given case should be considered with reference to increased sexual activity in certain patients, and with reference to the possibility of the conversion of an unobjectionable and harmless patient into an objectionable and dangerous one." 12. "Tryparsamide appears to have a beneficial effect on patients with resistant tabes, including gastric crises, even though the spinal fluid may be negative." 13. "Our results in the treatment of late paresis by tryparsamide in an institution for the insane are disappointing and do not lead us to continue it in this field. The unfavorable progress of certain unfavorable cases may apparently be hastened by the drug." 14. "We are still disposed to regard tryparsamide, because of the possibility of eye complications, as a last rather than a first therapeutic resort in asymptomatic neurosyphilis. In obvious early paresis, we recommend its use after or in conjunction with other forms of treatment. The experience of other observers has established its unfitness for use in most other aspects of syphilis, owing to its lack of spirillicidal power."

INJURIES TO THE URINARY ORGANS IN RELATION TO INDUSTRIAL ACCIDENTS

By ROBERT V. DAY, M. D., and HARRY W. MARTIN, M. D., *Los Angeles*

A resume of the diagnosis and treatment of injuries to the urinary organs in relation to industry.

Fractured pelvis and ruptured urethra, direct bladder injury, trauma to the spinal cord with secondary bladder involvement, direct injury to the kidneys, and epididymitis, constitute the greatest number of cases for which claims are filed for compensation.

Fractures of one or more vertebrae or injuries to the cord without fracture sometimes produce the so-called spinal cord bladder.

Kidney stone following injuries of the spinal cord is not an uncommon sequel.

The important and essential findings in severe injuries of the kidney are pain in the loin, extending through to the abdomen, fullness, dullness and tenderness in the kidney area, and hematuria.

The most numerous class of patients referred to the urologist for examination and report, on which may be based the question of compensability, are those with epididymitis.

If there is no existing source of bacteria, even though there is an injury to the testicle or epididymis, inflammatory reaction will not result.

DISCUSSION *by Granville MacGowan, Los Angeles; Charles P. Mathe, San Francisco; Miley B. Wesson, San Francisco.*

TRAUMATIC injuries involving the urogenital organs, as seen in Southern California, have increased apparently several hundred per cent in the past ten years. The development of new industries, particularly shipbuilding and oil production, and the enormous increase in population, together with the popularity of the automobile, are the principal factors causing the increase. Fractured pelvis and ruptured urethra, direct bladder injury, trauma to the spinal cord with secondary bladder involvement, direct injury to the kidneys, and epididymitis constitute the greatest number of cases for which claims are filed for compensation.

If the bulb and membranous urethra are injured, it is usually the result of falling astride some hard, firm object or in connection with fractured pelvis. As a rule, the prostate urethra escapes serious injury, and injury to the pendulous urethra is also rare. When the urethra is injured the symptoms are pain, bleeding, disturbance of urination and tenderness, with tumefaction. The location of the tumefaction, the point of obstruction to the catheter, and the consideration of the mechanical circumstances and causative force attending the accident will usually determine the point of injury and, in a rough way, its extent. The tumefaction is primarily due to extravasation of blood, to effusions, and secondarily to extravasation of urine and inflammatory exudate. Extravasation follows the fascial planes, usually discoverable in the perineum; also the scrotum and penis, and may involve the rectovesical space toward the peritoneum if the prostate urethra is much torn. Altogether, the extent of the extravasation is problematical. It may ascend to the diaphragm retroperitoneally, as in one case observed at a coroner's necropsy. In this case the rectum and peritoneum were torn somewhat. With injuries of the ilium and sacro-iliac joint, immense retroperitoneal hematomas over the psoas muscle may develop. (We saw this once in a case that recovered perfectly, where

the peritoneum was opened and examined by an abdominal surgeon just previous to our taking up the urological procedure as soon as he had closed the peritoneum.) The wide extravasation causes shock, and the extravasated blood and hematomas are apt to become infected. The extravasation sometimes extends down the inside of the thigh, requiring subsequent drainage. Knowing the extent of the injuries, the authors believe, if the patient is not greatly shocked, that the best procedure is to immediately open the bladder suprapubically, pass a retrograde staff through the bladder out to the perineum, and buttonhole the perineum down to the staff; a rubber perineal tube is then slipped over the end of the staff, which, when withdrawn into the bladder, carries the rubber perineal tube with it. When the tube is well in the bladder it is slipped off the staff and fixed with a skin suture in the perineal incision. The suprapubic bladder opening is finally sutured water-tight around a Pezzer catheter, with rubber tissue drainage in the prevesical space. This prevents further urinary infiltration, allows the extravasated blood and urine, plus the infiltrating exudate of cells and serum, to leak out, and thus prevents its final organization into thick dense scar tissue, which would otherwise result in a bad traumatic stricture if the patient in the meantime did not succumb from infiltration and sepsis. The classical procedure, of course, is to perform perineal section, insert a catheter into the bladder and suture the urethra if possible. We do not do this, as a rule, and especially in case of fractured pelvis, for the following reasons: First, it requires the exaggerated lithotomy position which, if the pelvis is fractured, might drive spicules of the fractured pelvic bones farther into the tissues; second, it consumes considerably more time; third, the edges of the urethra are usually so torn and contused that the sutures almost never hold. When the exudate has disappeared and the tissues lose their friability, a secondary suture may be attempted; but it is seldom necessary, since the great cause of the scar constituting traumatic stricture is the organization of the cellular exudate in the presence of infection into fibroblasts and adult scar tissue.

When the suprapubic incision is made, marked bloody extravasation in the loose prevesical and perivesical cellular tissue is usually found. Direct injuries to the bladder, particularly if the bladder is full, may in rare instances result in rupture—occasionally so small as not to be recognized, but allowing extravasation of blood and a little urine. In these latter cases, insertion of a rubber tissue drain into the prevesical space and the use of a retention catheter will usually suffice. Cystoscopy is justified only when the symptoms point to rupture of the bladder with little or no urethral injury and no fracture of the pelvis.

Prostatism: Occasionally, a man of prostatic age sustains a slight injury to some region of the body and suddenly develops difficulty in urinating, hematuria, perhaps epididymitis, or acute retention. He stoutly maintains that he has never had any previous urinary troubles and that the injury is entirely responsible for his condition. What really happens is that the psychic shock has so diverted his attention or so benumbed him that he neglected to urinate at the proper time; then his bladder became distended and he was unable to urinate. (As a matter of fact, most prostatics have their condition brought home to them acutely by neglecting to urinate at the proper time, and the distention causes prostatic engorgement, pain, and reflex spasm of the cutoff muscle, resulting in partial or complete retention. If the urine is infected, epididymitis may result.)

Fractures of one or more vertebrae or injuries to the cord without fracture, sometimes produce the so-called spinal cord bladder with residual urine, paradoxical incontinence, infection, and the typical cystoscopic picture. These cases really belong to the neurologist and neuro-surgeon. Their urinary symptoms will improve exactly in proportion to the regeneration of the nerve tissues involved.

It has been noted repeatedly by men doing much industrial compensation work that kidney stone following injuries of the spinal cord is not an uncommon sequel. This is not surprising, since residual urine and stasis, with resulting infection, predispose to both ascending and hematogenous infection.

Few men have had large experience with fractured or ruptured kidneys. Keyes, in the 1923 edition of his text-book, states that he has operated on four cases. Connell, in 1916, was able to gather only 841 cases, in a review of the literature. Tuffier and others have collected a series of cases—not their own—but these were of wartime injuries to combatants and, of course, are not quite comparable to industrial accident cases. The literature on the subject is somewhat meager. One of us (Day) has performed nephrectomy on four cases, with no deaths. In addition to these four, we have seen six other cases in which there was no doubt of injury to the kidney, but which recovered under expectant treatment. Still another two cases were seen at operation several years after the injury. The important and essential findings in severe injuries of the kidney are pain in the loin, extending through to the abdomen, fullness, dullness and tenderness in the kidney area, and hematuria. Hematuria often ceases in a few hours, even if the injury is considerable, due to the clotting of the escaped blood in the perirenal space, as well as blocking of the ureter by clots.

The amount of shock depends on many factors: First, associated injuries, particularly to the other abdominal viscera, diaphragm and lower chest; second, extent of injury; third, loss of blood; fourth, temperament, age, general health and associated chronic diseases of any other important organ.

It is amazing to observe how comparatively little shock is associated with the most extensive fracture of the kidney, provided the case is otherwise uncomplicated. For example, in two of our cases, in which the kidney was completely bisected about midway between the poles and in which nephrectomy was done in each instance about forty-eight hours after the injury, there was surprisingly little shock at any time preceding or after the nephrectomy. The injury may result in a rupture of the main renal vessels or the kidney may be shattered to a pulp. In case of complete rupture the blood

and urine escaping may be confined to the perirenal space. Again, it may rupture through the perirenal fascia and extend as an extravasation retroperitoneally, even down to the true pelvis. This happened in one of our cases and clinically resulted in a psoas abscess requiring secondary operation for drainage two weeks following nephrectomy. The rupture may be slight and result in only a subcapsular hematoma, which later becomes cystic. Many years ago one of us (Day) assisted the late Dr. N. H. Morrison in such a case. There had been little injury to the kidney itself, but we found a subcapsular cyst the size of a small lemon. On the other hand, the kidney may be entirely destroyed and converted into a cystic tumor—pseudo-hydronephrosis, and may later become calcified. For example, a boy 18 years of age sustaining injury to the back seven years previously, had aspiration of a cyst in his loin three times during the year following the injury; six years later he applied for compensation, claiming an injury to his back. X-ray revealed a calcified cyst in the region of the left kidney, the size and shape of the head of a new-born babe. Urological findings were negative, except that the ureter on this side could not be catheterized beyond 15 cm., and no urine or cyst fluid could be obtained through the catheter. The mass was excised piecemeal and with great difficulty, and consisted of a calcified fibrous wall containing clear fluid. All kidney tissue had disappeared. Some cases which, from the clinical aspect do not appear extensive at the time of the accident, may result insidiously in serious or complete destruction of the kidney. MacGowan cites a case in which he performed nephrectomy thirteen weeks after injury for a large mass in the flank with pronounced sepsis. In one case seen by the authors nine weeks after injury, nephrectomy was performed a few days later. At the first visit his temperature was 102.4, pulse 148, hemoglobin 40 per cent, and there was great bladder tenesmus. Cystoscopy was attempted, but the great mass of blood-clots in the bladder, both old and new, entirely interfered with vision. An attempt at evacuation of clots failed, partially because many were quite adherent to the bladder wall. It was necessary to do a suprapubic cystotomy and evacuate more than a pint of clots. The patient nearly died from shock. We hoped the hemorrhage would not recur, and decided that removal of the ruptured kidney would be a highly dangerous procedure at that time. However, he had another hemorrhage two days later. Evacuation of the clots through the former suprapubic incision was done. We still hoped. Two days later he had still another hemorrhage, and after a transfusion his hemoglobin was only 35 per cent. A nephrectomy was then done, followed that night by another transfusion. Convalescence was rapid and uncomplicated. This kidney had sustained a rupture extending from the pelvis into the perirenal space. The perirenal fat was cicatricial and the kidney itself markedly fibrotic. It was necessary to do an intracapsular nephrectomy. The patient rapidly took on weight and the rise in his hemoglobin was rapid.

Another patient seen recently was injured in the oil fields February 4, 1924. Shock was not pronounced and his pulse was under 100. Frank hematuria for the first eighteen hours. After that only microscopic blood. During the second night his pulse was feeble and intermittent, but never over 110. Operation following morning. After the kidney was delivered, a hole large enough for one to insert a thumb through the lower pole into its pelvis was seen. Much free bleeding when and after the lumbar fascia was incised, and much free oozing from kidney-bed as kidney was being delivered. Profuse bleeding from the rent in the kidney. Therefore, nephrectomy was decided upon. Uneventful convalescence except for the advent of diarrhea from fifth to tenth day post-operatively. He had 79 per cent hemoglobin the first day after the injury, with 50 per cent the morning following operation without loss of blood from the pedicle during the nephrectomy.

If the kidney is not too severely damaged, conservative surgery should be practiced; that is, incision, gauze packing, and drainage. Sometimes when the pressure is relieved by opening up the perirenal space, hemorrhage may be serious. It is up to the surgeon at the time of operation in this class of case to determine whether or not it is safe to leave the bleeding kidney in. In Watson's series, 27 per cent of simple ruptures resulted fatally with expectant treatment. Nephrectomy resulted in 22.5 per cent mortality in 132 collected cases of simple rupture. Conservative operative treatment—gauze packing, drainage or suture—gave a mortality of 8.5 per cent in 107 cases.

Unless loss of blood or some other reason demands immediate operation, the authors believe that it is wise to wait at least forty-eight hours before nephrectomy for the following reasons: First, it allows the opposite kidney to compensate; second, there is usually a superficial necrosis of the fractured surface so that bleeding will not be alarming while delivering the kidney; third, it gives time for associated injuries of other organs to produce symptoms indicating such complications; and fourth, by waiting the operation may sometimes be avoided.

The most numerous class of patients referred to the urologist for examination and report, on which may be based the question of compensability, are those with epididymitis. They usually have pus in their prostate and seminal vesicle juice obtained by massage; whether this preceded or was caused by the infected epididymis is not always easy to determine. Others have morning drop or cloudy first glass, often containing gonococci. Most have undoubtedly latent or active infection of the prostate, seminal vesicles or urethra, or any combination of these. Others have, in addition, infected urine from other causes, as in case of pyelonephritis associated or not with stone or tuberculosis or, as in the case cited above, hypertrophied prostate. The latter was riding in an interurban bus which suddenly swerved into a shallow ditch, injuring no one, but shaking up the passengers a bit and giving them a scare. This happened just out of San Diego. The old gentleman had been getting up at night to urinate for several years, and he had been in the habit of urinating frequently in the daytime. No doubt he was considerably dulled by reason of the excitement, and he didn't attempt to urinate again until he got to River-

side, sixty miles farther on, at which time he had difficulty. He came on to Los Angeles, developed more dysuria, then epididymitis, after which he was referred by the State Compensation Insurance Fund for examination. He was 70 years old, had a greatly hypertrophied prostate, his urine full of pus, and had a residual of six ounces. He had not been physically injured at all in the accident. It appears to us that in practically every suddenly occurring case of epididymitis in industrial accidents there is a latent or active infection in the urinary tract or its adnexa, or more rarely a focus of infection elsewhere in the body from which pyogenic organisms are carried through the blood stream to the more or less susceptible epididymis. In other words, if there is no existing source of bacteria, even though there is an injury to the testicle or epididymis, inflammatory reaction will not result.

412 West Sixth Street.

DISCUSSION

GRANVILLE MACGOWAN, M. D. (Brack Shop Building, Los Angeles)—I have given careful consideration to the opinion and advice of Doctor Day, with relation to traumatic injuries to the organs concerned in urination as set forth in this article. It is not usual that those who have to look after industrial accidents have sufficient experience with the surgery of the urinary organs to decide, without embarrassment, upon the best method of procedure in cases of grave injury. To avoid prolonged invalidism, sometimes lifelong, often to save life, for the injured person, and always to save the money of the employer or the insurance carrier, an intelligent decision as to what to do should be quite promptly made. This article of Day's, let us hope, may serve as a guide to those of less experience.

CHARLES P. MATHE, M. D. (Phelan Building, San Francisco)—Doctors Day and Martin have given us a very good resume of the treatment of injuries to the urinary organs sustained in the industries. They have pointed out the importance of conservatism in the treatment of renal injuries, such conservatism often saving the kidney by avoiding nephrectomy. Recently, in a spontaneous ruptured hydronephrosis due to complete block at the ureteropelvic junction by a wedge-shaped stone with tumefaction of the affected side, severe jaundice was noted. The urine was contained within Gerota's fatty capsule, and had caused tumefaction, pressing on the gall-duct. Following operation, by which about 120 cc. of urine was liberated from the fatty tissue surrounding the kidney and the stone removed by pyelotomy, the jaundice entirely cleared up. This is significant because one might confuse this symptom for gall-bladder disease.

Acute symptoms in persons affected by prostatism and movable kidney developing after accidents often occur. The average layman is prone to blame his affliction to an accident. How frequently does one woman attribute a breast cancer to an injury, and another a tubercular knee to the trauma of a fall. I have seen acute retention develop in prostates due to congestion of the gland following excesses in alcohol or voluntary retention of urine over a long period of time.

The question of the influence of trauma on the production of movable kidney was not discussed. It would be interesting to have the opinion of the authors on this diversified subject. J. J. Bell of England, who has had a large industrial practice in a manufacturing town, states that he has observed three hundred movable kidneys develop in girls whom he claims were employed too early in life, stood for long hours, and bore heavy weights. The girls having a congenital shallow, funnel-shape renal niche, however, were the ones usually developing the nephroptosis. Harris, on the other hand, doubts the sudden or acute origin of movable kidney, and states in order that a normally fixed kidney be injured, crushed or displaced, it is accompanied by a laceration of the perirenal tissue. He does not voice his opinion on repeated trauma or strain.

The authors have pointed out that, in order to have epididymitis resulting from a trauma, there must be a pre-existing source of infection. I have seen normal uninfected athletes repeatedly injured in the testis by a fast-moving hard rubber handball, causing tremendous pain at the time of injury, fail to develop acute epididymitis. On the other hand, an epididymis previously infected, subjected to the slightest trauma, often develops inflammation.

MILEY B. WESSON, M. D. (Flood Building, San Francisco)—This paper is an excellent and timely one, and is most instructive to the surgeon who sees an occasional industrial case. Two points are brought out that are vital ones to the insurance carriers, one being the question of responsibility for traumatic epididymitis and the other the treatment of closed traumatism of the kidney.

Any person with a prostatitis or seminal vesiculitis has a potential epididymitis, which may flare up after any sudden exertion, be it jumping on a street-car, falling off a scaffold, lifting a heavy weight, or receiving a direct blow on the testicle; whereas the same injury in the absence of an infected seminal vesicle will not affect the epididymis. In other words, it is very doubtful if epididymitis should ever be considered an industrial injury.

The treatment of rupture of the kidney has not yet been standardized, and unfortunately those organs are being handled today as were ovaries a generation ago, when it was a fad to remove them for trivial reasons. Insurance carriers want, when possible, their risks put back to work with both kidneys. Of all the internal catastrophies a ruptured kidney treated under modern conditions offers the best prospect of a complete recovery. In those unfortunates with a single kidney a severe injury to that organ is probably always fatal. The indications for exploration are (a) immediate severe renal hemorrhage which endangers the patient's life; (b) steady hourly rise in pulse rate; and (c) continuous moderate hemorrhage over many days, with consequent anemia. Conservative surgery consisting of gauze packing and drainage may be sufficient. The recognized indications for nephrectomy are (1) tearing of the renal pedicle; (2) laceration of the kidney in several places; (3) a tear extending toward the renal pelvis in a kidney whose short pedicle prevents delivering it so as to expose the rent for suturing; (4) an extensive tear in the renal pelvis which cannot be repaired or a complete tear across the ureter; and (5) hydronephrosis or other severe disease of the injured kidney.

Aside from severe hemorrhage there is no other justification for operation except infection. Since hematomata are easily infected, faithful supervision of the case is absolutely necessary if conservatism is attempted.

I have recently seen five cases of acute traumatic rupture of the kidney, all of which recovered under expectant treatment and were promptly returned to full duty, with sterile urine. One case had hematuria for thirty-three days, and the bleeding was stopped by injecting by gravity with a twenty-four-inch column of 13½ per cent sodium iodide solution to make the accompanying pyelogram. At that time the function of the damaged side was 50 per cent normal (total phthalein now normal). A sixth case was first seen six months after injury, and the pyelogram showed the scar of a complete perpendicular tear that had destroyed the middle calyx. This kidney was saved, although all rules of procedure were violated; the patient fell three feet and had hematuria; for twenty-two days he was treated for pneumonia because of the leucocytosis and fever, then was operated upon by a general surgeon because of a tumor mass in the left lumbar region the size of a "small watermelon," and a "gallon of urine" was evacuated; cystoscopy seven days later showed that all of the urine from the affected kidney was being discharged through the drainage tube, and the opposite kidney was infected. This man is back at work with two kidneys, both uninfected, and the damaged one has a function of 50 per cent normal.

Doctors Day and Martin have clearly shown that the mortality of traumatic rupture of the kidney has been reduced to a vanishing point by: (1) Operative intervention for the arrest of hemorrhage which otherwise rapidly proves fatal; (2) an appreciation of those signs which heralded the failure of expectant treatment; and (3) the prevention of infection.

USE OF SODIUM THIOSULPHATE IN METALLIC POISONINGS *

By GEORGE F. ROBERTS, M. D., *Salt Lake City, Utah,* AND ANDREW J. HOSMER, M. D., *Midvale, Utah*

Sodium thiosulphate is the logical drug of choice in the treatment of acute and chronic poisonings by a group of the heavy metals.

It materially shortens the length of disability caused by these poisons.

Moist applications of a 1 to 2 per cent solution of sodium thiosulphate are beneficial in the treatment of burns and dermatitis caused by arsenic and mercury.

DISCUSSION *by Gayle Mosely, Los Angeles; C. O. Sappington, Oakland.*

FOR many years chemists have used non-metallic sulphur as a precipitant for a group of heavy metals, among which are found arsenic, mercury, lead, copper, bismuth, and zinc. Toxocologists, however, apparently overlooked this precipitant action of non-metallic sulphur, and it is of only recent date that some of the non-metallic sulphur groups have been successfully used in medicine as a precipitant for these metals when taken into the body, either as a means of attempting death as a therapeutic agent, or as the result of occupation.

The chief non-metallic sulphur derivatives are calcium sulphide, calcium sulphite, and sodium thiosulphate. Sodium thiosulphate is a white crystalline substance slightly alkaline in reaction, and readily soluble in water. It is prepared by heating sulphur with sodium carbonate, dissolving this resultant in water, filtering, boiling the filtrate with sulphur, refiltering and concentrating. It converts all of the soluble toxic metals mentioned into insoluble non-toxic compounds.

The work on which this report is based, covering the treatment with sodium thiosulphate of acute and chronic poisonings by metals of this group, has been carried out at the Salt Lake County Hospital, St. Mark's Hospital, and the plant of the United States Smelting and Refining Company at Midvale, Utah.

The first cases we will report are those of two typical ones of arsphenamin dermatitis.

Case No. 1—Mr. J. H., American, age 53. Gave a four plus Wassermann test. He had a chronic syphilitic osteomyelitis, which had been operated upon several times, with a resultant suppurating fistulae. He was given .400 of salvarsan. In five days this dose was repeated. The day following this dose he developed a macular rash upon the face and hands. The next day the entire body was red. His hands, legs, and face were swollen. There was a serous exudate involving principally his face and arms. He was immediately given sodium thiosulphate .500 intravenously in 20 cc. of water. The following day he was given .900. With the second dose his symptoms began to disappear. By the time he had received five doses his symptoms were gone, and by the twelfth day he had completely recovered.

Case No. 2—Mr. W. W., age 52, was suffering with a syphilitic gummas of the arm and leg. Anti-syphilitic treatment was started. He received, covering a period of two months, nine does of salvarsan. The first course consisted of six doses, and the second three. Three days following the last injection the skin of the face and neck became red, dry, and itching. Two days later the eruption spread to cover his body. The skin was red, swollen, and weeping. The first day he was given .3 gm. of sodium thiosulphate intravenously, the second day .3 gm., the third day .45 gm. By this time the edema had practically disappeared and the redness was diminishing. He was given subsequent doses of .6, .9, 1.2, and 1.8 gms. By the fifteenth day his symptoms had all disappeared and his skin was normal.

These cases illustrate the effectiveness of this preparation in shortening an attack of arsphenamin dermatitis from two months or longer to as many weeks.

The success which we have had in the treatment of local dermatitis and burns due to the external application of arsenic have been equally as gratifying, as has that of treating arsphenamin dermatitis. These cases are too numerous to tabulate, and one case will probably suffice for the entire group, as all have reacted practically the same.

Case No. 3—Mr. C. P. O., American, age 57, employed in the bag-house at the smelting plant. He complained of stiffness of arms, legs, fingers, and toes. The exposed surfaces of his body were very red. There were several ulcers on his hands. Lotions had been applied to the skin, and ointments and boric acid dressings to the ulcers. Very little progress was noted. The skin continued to itch and burn, and the ulcers refused to heal. He was given six doses of sodium thiosulphate intravenously, ranging from .3 gm. on the first day to 1.8 gms. on the sixth day. By the sixth day the redness of the skin had diminished, and by the eighth day the itching had all disappeared. The stiffness and soreness of the muscles had completely gone. The ulcers on the hand had been treated additionally by moist applications of sodium thiosulphate and a solution of the drug had been given by mouth. The ulcers rapidly cleared and by the end of the second week had completely healed.

Previous to the use by us of sodium thiosulphate, the men who worked in the bag-houses and arsenic plants were required to take a shower and a complete change of clothing when coming off shift. Despite these precautions, there were numerous arsenic

*Read before the Salt Lake County Medical Society.

burns and arsenic dermatitis. Noting the very favorable effect of solutions of sodium thiosulphate externally, we recommended that the employes in the bag-house and arsenic plants be required to take a daily shower in a solution of sodium thiosulphate. The men are now required, when coming off shift, to take a shower bath from a tank containing a 1 per cent solution of sodium thiosulphate. After this they then take their cleansing bath and change of clothing. They are also given an ointment of 1 gm. sodium thiosulphate to the ounce. This is put in the nostrils, around the eyes, and in the ears. Since the introduction of these precautions, arsenic burns, dermatitis and irritations of the nose and eyes, and abdominal colics, have become the exception rather than the rule; the men are happier, do better work, and little complaint is heard concerning their occupation.

Our experience with acute and chronic lead poisoning has been more phenomenal than has been that of arsenic; in fact, it has now become the routine that all men applying for treatment and complaining chiefly of vague abdominal pains, even before the blood shows any change, are immediately given intravenous doses of sodium thiosulphate, with the result that, after two to three doses, they are completely free from pain. As with arsenic, so with lead, these cases have been too numerous to give a complete tabulation here, but two cases, one from the smelter and one from a city plumber, will probably suffice as typical group pictures.

Case No. 4—Mr. J. S., Serbian, age 40, had been away from duty for one week on account of abdominal pain. His family physician had used all of the better known remedies for lead poisoning, with practically no effect. At the beginning of the second week he applied to us for treatment. The first day he was given 1.2, 1.6 and 1.8 gms. of sodium thiosulphate intravenously. The second day the dosage was repeated. By the third day his pain had all disappeared. The third day he was given two doses of 1.6 and 1.8 gms. each. The fifth day he returned to work a well man, and has not applied for any treatment since that time.

Case No. 5—R. J., negro, plumber, age 32. For two months he had been practically incapacitated on account of abdominal pain. One month of this time had been spent in hospitals. On admission to the county hospital, he was in such pain that his thighs were almost completely flexed on his abdomen. His bowels had not moved for four days. He was given ½ grain morphine, 2 ounces of magnesium sulphate, and three doses of 1.6 gms. each of sodium thiosulphate the first twenty-four hours. The next day his pain was greatly relieved. The sodium thiosulphate was again repeated. The second day his pain had practically disappeared. The third, fourth, and fifth days he was given two doses each day of 1.2 gms. By the sixth day his pain had all gone, and he left the hospital to return to his work.

Our experience with mercurial poisonings has not been as extensive as it has been with arsenic and lead, but we believe that the results have been sufficient to warrant the recommendation that this chemical be kept on hand in all emergency hospitals where a dose could be immediately given in any case of mercurial poisoning.

Case No. 6—Mrs. J., American, age 23, took by mouth thirty 1-grain tablets of bichloride of mercury. She was found about four hours later. She stated that she had vomited about one hour after taking the tablets. She was taken to the Emergency Hospital, where she was given a stomach lavage, and later was brought to the County Hospital. At this time she was passing blood from the bowels and vomiting blood and bile. The urine was scanty and smoky. The abdomen was distended and tender, especially over the ileocecal region. By March 1 the tongue was so swollen that it practically filled the mouth. The teeth were loose and there was marked necrosis of the gums. March 7 she aborted a six weeks' partially macerated foetus. March 8, patient in partial coma. Refused all food or liquid by mouth. March 10, .3 gm. sodium thiosulphate was given intravenously. March 11, 45 gms. March 12, 6 gms. March 13, 9 gms. March 15, 1 gm. March 17, 1.2 gms. March 19, 1.8 gms. By March 11, the day following the first dose, the patient was some brighter, the tongue not as badly swollen, and she asked for food. March 15, appetite good. Tongue decreasing in size. Teeth very loose, but necrosis of gums is improving. March 20, tongue practically normal. Gums greatly improved. Loose teeth and some necrotic bone removed. April 1, sent to the county jail. The mouth is a little tender, but otherwise she is practically normal.

Case No. 7—J. B., American, age 24, took two tablets of bichloride of mercury, 7½ grain, in mistake for other medicine. He discovered his mistake in about one hour. A stomach lavage was immediately given and an intravenous dose of 1.6 gms. of sodium thiosulphate. This dose was repeated in four hours. The following day the urine gave a test for mercury. He was given eight doses averaging about 1.5 gms. of sodium thiosulphate. He made an uneventful recovery with no symptoms of mercurial poisoning, except a looseness of the bowels and some tenesmus.

Case No. 8—R. H., age 28, took 100 1-grain tablets of bichloride of mercury. He was found about one and one-half hours later. At this time he was vomiting blood, and passing blood from the bowels. He was sent to a hospital, where he was given sodium thiosulphate both by mouth and intravenously. The hemorrhage from the bowels, bladder and stomach continued, and he died twelve hours later.

Case No. 9—D. H., age 45, had scabies. He put one heaping tablespoonful of powdered bichloride of mercury in a pint of water and rubbed it on his body. When seen by us four days later he had a complete suppression of urine which had been present for two days; practically the entire surface of his body was burned. He was given sodium thiosulphate, 1 gm. intravenously every eight hours, and was given 15 gms. the first day by mouth and afterward 5 gms. daily. Moist applications of a 2 per cent solution were applied to the burned surfaces. The first two days after treatment was started he continued to pass blood from the bowels. This disappeared, but the bowels remained very loose. The burned areas greatly improved, but he died on the ninth day, having then had a complete suppression of urine for seven days.

Some of the earliest work on the use of sodium thiosulphate in metallic poisonings done by McBride and Dennie, they advocated the following dosage: .3 gm. first day; .45 gm. second day; .6 gm. third day; .9 gm. fourth day; 1.2 gm. sixth day, and 1.8 gm. the eight day. We have found that these dosages can be greatly increased with a resultant more rapid modification of the symptoms and with no unfavorable manifestations or discomfort to the patient. In our earlier work we followed the dosage of McBride and Dennie, but in our later work we have been using, as an original dose, 1 to 1.2 gms. and as high as 1.8 gms., and have repeated this dose from two to three times daily. In all cases treated we gave sodium thiosulphate by mouth daily. The first day the patients were given 15 gms. in 500 cc. of water, and daily thereafter 5 gms. in the same amount of water, distributed as small drinks throughout the day.

CONCLUSIONS

1. Sodium thiosulphate is the logical drug of choice in the treatment of acute and chronic poisonings by group of heavy metals.

2. It materially shortens the length of disability caused by these poisons.

3. Its more general use by corporations where the health of employes is influenced by these metals should be urged.

4. Moist applications of a 1 to 2 per cent solution of sodium thiosulphate are beneficial in the treatment of burns and dermatitis caused by arsenic and mercury.

5. In acute cases of poisonings by these metals, the original dose of sodium thiosulphate should be 1 gm. intravenously given once, twice or three times daily, depending upon the symptoms.

6. In our series of over one hundred cases we have had no reactions in either large or small doses, and the only effect we have seen between the large and small doses is a more rapid amelioration of symptoms.

DISCUSSION

GAYLE G. MOSELEY, M. D. (National City Bank Building, Los Angeles)—The paper of Drs. Roberts and Hosmer serves to emphasize the importance of scientific medicine to industry. I hope in the near future some ethical way may be found to bring to the attention of industry the developments in medicine and surgery that have a direct relation to business. This could be done through the publications of the various trade associations. Any measure that serves to lessen the period of disability of a sick or injured employe not only lessens the suffering of the employe, but means an actual saving of money for both employer and employe. If the employe receives compensation during his period of disability it is much less than would be his actual earnings.

I am particularly interested in the results obtained from the sodium thiosulphate in lead poisoning. Notwithstanding the great advance made in the prevention of this trouble, it is still seen quite frequently in industrial cases. Many of the smaller concerns, such as small plumbing and painting contractors, take no special precautions to prevent this disease. Sometimes special conditions arise in large plants that cause much sickness and suffering to the employes, as well as expense to the employer, before the necessary steps can be taken to prevent the trouble. Within the past year one of the largest shipbuilding concerns in the bay district had a contract to tear down a number of Government vessels. These boats, of course, had all been painted many times with white lead, and the result was a very large number of cases of lead poisoning, some of which were quite serious. In fact, the condition was so bad that the insurance carrier had to cancel the risk, at considerable loss. This example is cited simply to show that lead poisoning is always with us.

It seems to me that early recognition of these cases is of great importance, in order that treatment may be administered before changes take place in the blood. Doctors engaged in industrial medical practice should always be on the lookout for cases of lead poisoning, as they often occur unexpectedly and from plants where ordinarily one would not expect such cases to occur. If the readers of the Journal will bear in mind that lead poisoning is much more common than generally supposed, and make early diagnosis and apply the treatment recommended in this paper, it will be another long step forward in showing the business man that he needs the doctor in this business.

C. O. SAPPINGTON, M. D. (Hutchinson Building, Oakland)—Drs. Roberts and Hosmer have brought to our attention a very interesting chemotherapeutic reaction. The administration of calcium sulphide to workers exposed to lead is not new, and is alluded to in the literature by Sir Thomas Oliver, Marvin Shie, Alice Hamilton, and other experts on lead poisoning; but the intravenous injection of sodium thiosulphate as a rational therapeutic procedure in cases of metallic poisoning, is new and certainly seems full of promise, in the light of the experience of Roberts and Hosmer.

It appears that sodium thiosulphate would be the logical drug of choice in acute and chronic cases of poisoning from the heavy metals, with the exception of chronic plumbism. We know from the excellent researches of the Harvard Lead Unit, which recently completed three years of experimental and clinical work on various phases of lead poisoning that, in the chronic type of lead intoxication, the lead is stored in the compact portion of the long bones. Various substances were tried, in order to ascertain just what was most efficacious in releasing the stored lead. Among other factors, it was discovered that a distinct change in the acid-base equilibrium toward the acid side would release the combined lead and set it free in the circulation so that it might be eliminated (of course, this is a dangerous process and may give rise to acute symptoms). Phosphoric acid in dilute solution was found to be the substance causing the setting free and excretion of lead in greatest amounts, as checked by estimations of lead in the urine and stools. I must confess my ignorance as to the relative merits of the thiosulphate of sodium as a compound which will cause lead excretion; but if it was possible that the insoluble, non-toxic compound formed by the thiosulphate could be eliminated by way of the urinary or gastro-intestinal tracts, after lead had been set free in the circulation by the use of dilute phosphoric acid, it would appear that the procedure of Drs. Roberts and Hosmer would be a very valuable adjunct in the deleading process in cases of long-standing chronic plumbism.

Dr. Moseley has spoken about the importance of lead poisoning as a problem of industrial medicine. I should like to add just a few words to what he has said. Many cases of lead poisoning are not recognized in industry because the industrial physician has not taken the trouble to familiarize himself with the progress made in the recognition of early signs and symptoms of this affection. Lead intoxication contributes over half of all the cases of poisoning due to contact with metallic substances used in various industrial processes. Where a lead hazard is definitely known to exist, certainly all the intelligence possible should be brought to bear on the aspect of prevention.

Transfusion of Lymphocytes—A patient in an advanced stage of generalized lymphosarcoma, whose white blood cells were 6400 per cubic millimeter and lymphocytes 15.5 per cent, was transfused by G. R. Minot and Raphael Isaacs, Boston (Journal A. M. A., June 6, 1925), with 450 c.c. of blood from a patient with chronic lymphatic leukemia, whose white blood corpuscles numbered 89,000 per cubic millimeter and lymphocytes 95.6 per cent. This transfusion produced no greater benefit than one with normal blood. The transfusion caused the percentage of lymphocytes in the recipient's peripheral blood to be increased immediately about threefold, and their absolute number nearly four times. The number and percentage of lymphocytes dropped almost to their pretransfusion level within thirty-five minutes of the completion of the transfusion, and reached this level within at least two and a quarter hours without a subsequent significant change. There was no evidence that the transfused lymphocytes were destroyed in the peripheral circulation.

Tryparsamide in Treatment of Neurosyphilis—Continued observation, with a larger number of cases and over a longer period of observation, has convinced Udo J. Wile and Lester M. Wieder, Ann Arbor, Mich. (Journal A. M. A., June 6, 1925), of the value of tryparsamide in producing clinical betterment in almost 30 per cent of a carefully selected group of cases. In the main, clinical improvement was not paralleled by sriking changes in the spinal fluid, many of the most strikingly improved patients retaining, after protracted treatment, the changes in the fluid that were found at the original examination. In a small group of cases in which spinal fluid change was noted, clinical betterment was found to be associated with such improvement. When improvement occurred clinically, this was indicated in a large majority of the cases during the first and second courses of treatment.

BACKACHE IN GYNECOLOGY—A STUDY OF ITS FREQUENCY AND MEANING

By Frank W. Lynch, M. D., *San Francisco*

(From the Department of Obstetrics and Gynecology, University of California Medical School)

As a result of a preoperative and follow-up study of 608 gynecologically operated cases, we believe we are justified in the following conclusions:

1. Sacral or sacrolumbar backache constituted a complaint in 48 per cent of 608 gynecologic cases, being found in 8 per cent of the ovarian tumors, 31 per cent of the fibroids, 46 per cent of pelvic inflammatory disease, 58 per cent of suspensions, 75 per cent of relaxed vaginal outlets, and 23 per cent of procidentia.

2. Backache may be ascribed to gynecologic pathology because it remained cured for periods ranging from one to eight years in 77 per cent of the 48 per cent of the 608 gynecologic cases that had this symptom.

3. Backache which was cured by gynecologic operation occurred in the following percentages of the cases that had this preoperative symptom: 100 per cent in ovarian tumors, 84.5 per cent in marked retroflexions, 81 per cent in extensive vaginal relaxations, 73 per cent in chronic pelvic inflammations, 68 per cent in fibroids, and 36 per cent in complete procidentia.

4. Backache in gynecologic conditions is due chiefly to pelvic congestion.

5. Orthopedic conditions were responsible for between 17 per cent and 23 per cent of the total number of backaches of the series.

Discussion *by Alfred Baker Spalding, San Francisco; Titian Coffey, Los Angeles; Walter I. Baldwin, San Francisco.*

MODERN medicine clearly demands that anyone who attempts a study of backache should proceed with the greatest caution, because the individual with backache usually has a number of coexistent conditions, any one of which may cause the complaint. The student of backache in gynecology must keep in mind that, while the symptom may arise from a number of bone, joint, visceral or pelvic lesions, it may come equally well from muscular or mental fatigue alone and without any associated condition, or from several of them in combination. Fatigue is often urged as the most common cause of backache, and, because nearly all gynecologic cases complain of fatigue, many writers urge that backache in gynecology is due rather to fatigue than to the pelvic condition.

In older times, backache in women was ascribed usually to some pelvic disorder and little attempt was made to find any orthopedic condition. More recently the pendulum has swung the other way, and the orthopedist now is often at fault for failure to rule out pelvic pathology by a routine vaginal or rectal examination. There is considerable excuse for this, however, since many contributors to medical literature urge that backache is only rarely due to a gynecologic condition. A review of several of these articles strongly suggests that many of them present the author's *impressions* rather than deductions from a series of well-controlled observations.

From the standpoint of pure theory, it seems reasonable to believe that pelvic disorders may cause backache, since women with comparatively slight pelvic pathology frequently complain of backache only at the time of menstruation or of menstrual congestion. There is abundant proof to show that many women complain bitterly of backache until they are relieved by the cure of their dysmenorrhea, or of a marked uterine retroflexion. Backache in these cases is confined to the sacral or lowest lumbar region and most commonly is referred to the upper sacrum. It is not likely to be confused with the backache of fatigue which is usually referred to the dorsal region, but is frequently confused with orthopedic conditions.

Our study of backache in gynecology is developed from a series of 608 cases which have been studied sociologically and medically before operation, and who have been followed accurately for a minimum of one and a maximum of eight years. The cases comprise 505 laparotomies, many of which had vaginal work in addition, and 103 cases in which vaginal repair work only was done. In calculating our results, we have considered that when the patient was permanently cured of backache by gynecologic operation we were justified in concluding that the backache was due to the pelvic pathology, although there is the chance that the good result might be due occasionally to an improved general condition. We are fully conscious of the many errors that may attend such a paper, largely because the cases were not developed years ago primarily for this investigation. We realize that our series, to be of the greast value, should be studied in similar groups of like postural defects, of stance, etc., as long since advocated by Dickinson, or after they had been arranged in various subdivisions, according to their nervous reactions. Our cases, moreover, should have been contrasted with normal controls. While we could have arranged a series on this general plan, it would have been too small to be of much value, and for that reason we have confined our study of backache to groups of similar pelvic pathology.

Backache in the sacrum or in the lower lumbar region was a pre-operative symptom in 48 per cent of the 608 cases, and did not constitute a complaint in 52 per cent of the cases. Our follow-up suggests that it was due to a gynecologic condition in 37 per cent of the entire series, since the complaint disappeared following operation and did not again constitute a symptom during the one to eight years' follow-up period after operation. This 37 per cent of the total series constitutes 77 per cent of the cases complaining of backache. There are, in addition, 17 per cent of the cases having backache whose backache was not cured by the operation, and another 6 per cent whose backache was only improved after operation. We believe these figures indicate that orthopedic conditions may have been responsible for at least 17 per cent of all the sacral lumbar backache in this series, and possibly for part of the 6 per cent of cases whose backache was only improved following operation. At any rate, the backache was diagnosed as orthopedic prior to operation in a very considerable number of cases in the series, all of which were included in this review which attempts a study of the frequency and meaning of backache in gynecology.

Our 608 cases consisted of 12 ovarian tumors, 60 fibroids, each tumor being of more than 8 cm. diam-

eter, 267 pelvic inflammatory diseases, 166 marked retroflexions, 56 generally relaxed vaginal outlets, including cervical lacerations and infections, and 47 cases of complete prolapse. The cases were first studied in the above divisions. In order to study the influence of injury and defects of the pelvic floor as a cause of backache, the various groupings were further subdivided as (1) the pathology was entirely intra-abdominal, or (2) presented only cervical pathology in addition, or (3) combined vaginal relaxations and cervical pathology, with intra-abdominal conditions, or (4) was confined entirely to cervical lacerations and infections, together with vaginal relaxations.

The pelvic inflammatory cases consisted entirely of chronic cases. They were studied in two general groups, accordingly as they were mild or more severe cases. The former consisted of 134 cases, in which at operation it was necessary to remove only one tube and ovary, or rarely both tubes and one ovary, with or without vaginal work in addition. Nearly all of this group presented posterior displacements of the uterus which were brought about by the inflammatory process. Such cases must be carefully distinguished from the non-inflammatory type of displacement, to which they bear no resemblance. The more severe type of pelvic inflammatories were represented by 133 cases, in which it was necessary to perform a hysterectomy. These were studied in groups of supravaginal (83), and panhysterectomies (50), subdivided again according to the treatment of the adnexal disease and vaginal floor.

Low backache was present in but 8 per cent of the ovarian tumors, in 31 per cent of the fibroids, in 46 per cent of the pelvic inflammatory cases, in 58 per cent of the retroflexions, in 75 per cent of the marked vaginal relaxations in women in the menstrual age, and in only 23 per cent of the complete prolapse cases. Taking the series as a whole, backache was cured by operation in 8 per cent of ovarian tumors, in 22 per cent of fibroids, in 33 per cent of pelvic inflammatories, in 50 per cent of retroversions, in 60 per cent of vaginal relaxations, but in only 8 per cent of the complete prolapse cases. Of the cases in which backache was a pre-operative symptom, the complaint was cured by the gynecologic operation in 100 per cent of the ovarian tumors, in 84.5 per cent of the retroflexions, in 81 per cent of the relaxed vaginal outlets, in 73 per cent of the pelvic inflammatories, in 68 per cent of the fibroids, and in only 36 per cent of the procidentias.

Detailed study of our cases shows that sacral-lumbar backache in gynecology follows closely upon chronic disturbances of the pelvic circulation. Thus, low backache is uncommon with uncomplicated medium size (more than 8 cm. diameter) ovarian tumors and fibroids unless there are degenerations, or incarcerations, or the fibroid is a submucous growth with hemorrhage as a prominent symptom. Backache is often absent even when the circulation is developing rapidly in quickly growing but otherwise uncomplicated tumors because there is, we believe, no chronic passive pelvic congestion. Backache often disappears when a rapidly growing uncomplicated tumor rises from the pelvis into the abdomen, reminding us of the similar finding in the third and fourth month of pregnancy.

Added support is given to the above theory by study of the retroversions and retroflexions. By simple retroflexion we mean the retroflexions not complicated by pelvic inflammatory disease or by cervical or vaginal lacerations or infections; that is to say, the cases in which the grossly apparent pathology is limited entirely to the retroflexion. We are perfectly aware that there is not complete agreement that the so-called simple retroflexions and retroversions cause symptoms. We have, however, elsewhere *proved* by a follow-up study of a considerable number of cases that retroflexed uteri of the third degree cause definite symptoms when the uterus is enlarged, and the displacement has followed parametrial injuries during parturition; also, that the following conditions are factors in the development of symptoms: enlargement of the uterus because of chronic passive congestion, varicose veins in the broad ligaments, and the prolapse of enlarged ovaries into the pelvis. We do not believe that retroflexions of other types are a cause of symptoms.

An entirely different type of retroversio-flexions is found in pelvic inflammatory cases. In this group, the retrodisplacement is secondary and represents nature's effort to wall off a pelvic infection. The uterus is not usually enlarged, since the chief lesion is in the tubes or ovaries. Backache is not a frequent complaint in the latest stages of these infections, since the pelvic circulation has been cut down after the infection has become limited. Our study shows that backache was frequent in chronic pelvic inflammatory cases when the uterus was enlarged and congested, and there was frequent or severe bleeding. It is worthy of emphasis that backache was present in 58 per cent of the simple retroversions and in only 46 per cent of retrodisplacements associated with tubo-ovarian inflammation. The backache was cured by gynecologic operation in 85 per cent of the uncomplicated retroflexions, in 87 per cent of the mild inflammatories associated with adherent enlarged uteri in retroflexion or retroversion, and in only 64 per cent of the latest stages of the more extensive types of pelvic inflammations.

The influence of pelvic circulatory disturbance in causing backache is shown in another phase of retroflexion. A retroflexion which for years has caused symptoms will become symptomless after the menopause has cut down the pelvic circulation.

A review of the relaxed vaginal outlet and endocervicitis cases gave interesting findings. Backache was present in 75 per cent of women under 40 years who presented only this type of pelvic pathology. It was cured by gynecologic operation in 81 per cent of the cases. Study of our tables also shows that the percentage of backache is increased in any group of intra-abdominal pelvic pathology if the cases have vaginal relaxations in addition. In marked contrast to the findings in relaxed vaginal outlets are those in prolapsus, which is, of course, the last degree of vaginal relaxation. Backache in complete prolapse was present in only 23 per cent of the cases, and was cured by operation in but 36 per cent of them. This is opposed to a frequency of backache in 75 per

cent of the vaginal relaxations in the comparatively young, of which 81 per cent were cured by operation.

The marked difference in the percentage of backache in relaxed vaginal outlet cases and in those of prolapse can be explained only on the basis of circulatory restrictions and loss of function in the procidentia cases. Many of the prolapse cases stated that they had backache when they were younger and before the uterus "came down." The large number of backaches in procidentia remaining uncured by operation calls attention to the fact that these women usually have markedly relaxed or pendulous fat abdominal walls, with bad posture and other static conditions.

As a result of a pre-operative and follow-up study of 608 gynecologically operated cases, we believe we are justified in the following conclusions:

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4. Backache in gynecologic conditions is due chiefly to pelvic congestion.

5. Orthopedic conditions were responsible for between 17 per cent and 23 per cent of the total number of backaches of the series.

University of California Hospital, San Francisco.

DISCUSSION

ALFRED BAKER SPALDING, M. D. (Stanford University Hospital, San Francisco)—Doctor Lynch should be congratulated for his statistical study of sacral backache in women. No doubt to many gynecologists it will be interesting to learn that with a large group of clinic patients suffering from marked pelvic lesions, 52 per cent failed to mention sacral backache as one of their symptoms. From my clinic and private experience in gynecology, I had come to the erroneous opinion that practically all women in the child-bearing period have sacral backache.

Keiffer in 1900 described special cells found in the uterus of women which resemble ganglion cells of the sympathetic type, a majority of which are on the surface of, or near the uterine blood vessels of all sizes. Though existing throughout the mucosa they are especially found along the vessels and under the epithelium of the glands. Keiffer states that the uterine ganglia undergo certain changes as do those of the cerebrospinal system in general as a result of pathological changes within the uterus such as growths, suppurative conditions or inflammation.

The sacral plexus separated from the pelvic viscera only by the pelvic fascia readily receives its share of general pelvic infection. It is well to remember that after operation, these nerve changes being chronic, demand many months of rest before returning to the normal. After the menopause or after operations or treatments which reduce or stop the periodic pelvic congestion, women are less disturbed with sacral pains.

I agree with Dr. Lynch that much relief can be given younger women by procedures which aim to lessen pelvic congestion. Also I agree with the statement that about 25 per cent of backaches are associated with conditions outside the pelvis, and when a patient complains of backache I urge that the doctor should examine her back. Some of our most grievous errors have been due to this oversight.

TITIAN COFFEY, M. D. (1136 West Sixth Street, Los Angeles)—The symptom and complaint of backache in women is one of the most trying and obstinate conditions the gynecologist or obstetrician has to deal with. Doctor Lynch's careful study gives us many interesting points and much of value in helping these cases.

His record of relief of pain by operation in selected cases is very encouraging, but we all know a certain number of cases are not relieved by operation. Many cases with extreme retroflexion of the uterus never complain of backache at all, while others, especially women who have borne children, may have a well involuted uterus in proper position following confinement with apparently no pelvic pathology and yet complain severely of backache. In these cases we must look for another cause for the trouble and we find it is frequently due to some focus of infection elsewhere, either in the teeth, the tonsils, or an unrepaired cervix giving rise to an endocervicitis. A more frequent cause, however, in my opinion, is the strain put upon the pelvis at the time of confinement, especially in operative cases where a large fetal head has come through a small pelvis either after a long hard labor or the use of forceps. Here we get a stretching of the pelvic ligaments, a relaxation of the pelvic floor following the delivery and a loosening of the ileo-synchondroses. This later is frequently shown and the small amount of displacement that takes place by the x-ray picture. These cases should be referred to the orthopedist for necessary corrective measures. Frequently the backache will be due to improper posture or to flat-feet.

Again the same condition comes in women with loose, flabby abdominal walls that give practically no outward support to the intestines, and here we have a condition of weight pressing upon the pelvic organs which increases the discomfort materially, if the pelvic floor is overstretched and loosened and not giving the proper support.

In studying these cases we must always keep in mind the important point that Doctor Lynch brought forth in the first of the paper that many other causes than pelvic congestion may give rise to this condition.

WALTER I. BALDWIN, M. D., 380 Post Street, San Francisco)—Doctor Lynch is indeed to be congratulated for the presentation of such a splendid statistical paper on backache in relation to gynecologic conditions. While his statistics bear out the impressions held by many orthopedic surgeons, it is valuable to have such a splendid piece of work to give such impressions a basis of scientific fact.

That the disturbance of pelvic circulation is fundamentally the final factor in the incidence of "pelvic backaches" seems logical and is an established fact.

That the character of the backache should be determined is also important. In acute lumbosacroiliac backaches due to trauma the symptoms are nearly always exaggerated by menstruation, and where the patient has been suffering from dysmenorrhea, oftentimes pelvic treatment may be imperative before a cure of the symptoms can be had.

The large number of backaches encountered and cured by correction of relaxation in the pelvic floor in Doctor Lynch's series is indeed instructive. I believe this condition has probably not been given sufficient attention by orthopedic surgeons, whereas a reference to the gynecologist might have produced the result. Undoubtedly a closer co-operation between the gynecologist and the orthopedic surgeon is greatly to be desired, but there will always be cases where such consultation is difficult

or impossible to obtain. In such instances it may be noted, for instance, that pain localized in the midsacral area is almost always traceable to an intrapelvic cause in women, and to prostatic and seminal vesicle conditions in men. The back pain is reflex in character and may be projected at any point along the reflex arc of the root innervation of the particular pelvic organ involved.

A marked deviation of the spine to either side should indicate that there was an orthopedic condition, at least co-existent.

One cannot but feel in Doctor Lynch's debt for much enlightenment on a very important subject.

THE DOCTOR IN INDUSTRIAL MEDICINE

By EDWARD F. GLASER, M. D., *San Francisco*

Industrial medicine is with us and has come to stay, and every day the industrial physician or surgeon is coming to a more and more prominent position in the profession.

Industrial medicine is not simply a field for the ordinary practice of general medicine and surgery; it is a development which, in its broader sense, takes in preventive medicine.

The industrial surgeon of today believes in and advocates physical examination of all applicants for work and the keeping of exact records of those examinations.

Industrial medicine has an active business side requiring organization.

There is a struggle on now to prevent industrial medicine becoming an industry rather than a science.

The business manager for doctors is a somewhat abhorrent idea to me. It seems the last word in commercializing the profession.

There can be no finer contribution to society than speedily to return to their occupations those who, unfortunately, are overtaken by industrial catastrophies.

The final test of an industrial surgeon is the value of the service he renders. The capacity of the industrial physician to serve is measured by the man himself, his preparation, his vision, and most of all, his attitude toward his job.

DISCUSSION *by E. C. Fishbaugh, Los Angeles; Philip Stephens, Los Angeles; E. W. Cleary, San Francisco; C. W. Clark, San Anselmo.*

THE more one thinks about the subject of the doctor and industrial medicine, the more complex and involved it becomes. It may seem simple at first if you only consider the doctor and his material interests, while in fact, and in the larger human sense, the question has other important factors besides the doctor—there is the patient himself, the industry and the public, and these interests are all entangled with each other. The medical brain is trained to seek out a pathological condition, to diagnose it, to treat it, to cure it if possible, and receive adequate compensation for so doing. Rarely does the medical brain recognize any duty beyond that—rarely does it acknowledge any duty to the community. It is somewhat unfortunate that medical men are, by reason of the intensive study that they give their profession and the necessary limitations in the training at the medical schools, seldom endowed with a broad comprehensive constructive grasp or viewpoint on questions. Doctors are taught to understand scientific facts, but not the fundamental and ordinary things of life, which is preparatory to saying that doctors are handicapped when they come in contact with the highly trained executives of a commission, a corporation, or an insurance company, just as they are, generally, in dealing with the legal profession.

Industrial medicine is with us and has come to stay, and every day the industrial physician or surgeon is coming to a more and more prominent position in the profession. Industrial medicine is young, but it is growing by leaps and bounds, and promises very soon to become one of the leading, if not the leading specialty of medicine. But it will call for and will produce a highly specialized, a differently constituted and educated doctor from the old family physician.

The doctor who merely accepts employment to render emergency services in cases of accident, and often to protect the interests of the employers as to claims, is not an industrial physician in the truest sense. This type was the old-time doctor who was primarily a first-aid man. It was this class of medical men who earned the stigma of the "company doctor" and did not command the respect of either the employers, the employes, or of his professional colleagues. This type, while we may always have some of them with us, still is gradually growing less, and the industrial surgeon forging forward to the foremost rank of the profession, is honorable and is honored and is rich in opportunities for human service.

Industrial medicine is not simply a field for the ordinary practice of general medicine and surgery, it is a development which, in its broader sense, takes in preventive medicine (sanitation in prevention of disease, control measures for communicable disease, safety first for prevention of accidents)—it takes in the rehabilitation of the injured man, the restoration as nearly as possible to his former place in the economic world. It must consider the means for better health and contentment of the workers, means for increased production and decreased labor turnover. The industrial surgeon of today believes in and advocates physical examination of all applicants for work and the keeping of exact records of these examinations. This examination, if done with the proper thoroughness, is of great value to both employer and employe. The industrial physician comes into intimate contact with almost every branch of the industry, not only with the required medicine and surgery, but with the safety and welfare departments, and should with the employment office. But on the other hand physicians and employers must realize that industrial medicine is, in a measure, a compromise between the ideals of medicine and the necessities of business. Physicians have reluctance in accepting the materialistic viewpoints of employers, and conversely have difficulty in persuading employers to accept their professional points of view. In approaching the compromise, the fact should not be overlooked that medical service in the industries, to be of the greatest possible usefulness, must benefit primarily the working people, and then the benefit to industry naturally follows and the industrial surgeon justifies his existence. But we must recognize that industry exists, not primarily for ideals, but for the production of an output for a profit.

Industrial medicine has an active business side requiring organization. The corporations and insur-

ance companies must have an income and are often concerned in that more than in the patient or his efficiency. They must think of getting the injured man back as quickly as possible and with the least possible expense. Of necessity, they must continue organizing and concentrating, learning to give humane consideration, as they find it pays. Organizations that have grown up must make terms to deal with the small employer, with the result that, in having to give much service, it must make the good doctor work too cheaply or must employ doctors lacking in experience and, therefore, cheap in price.

There is a struggle on now to prevent industrial medicine becoming an industry rather than a science. Where the cold commercial side is considered and emphasized, doctors with ideals do not care to go into it, or, if they do, they find soon they cannot express themselves. They must put one side, ideals, for money consideration in the creating of efficiency of business rather than that of science. As a rule, the doctor has no business training and cannot compete in the world of business as in the world of science. Unfortunately, sometimes the doctor's ideals of giving humane service are changed by the pressure of commercialism and by our social system. He desires to meet the standards of his neighbors—must have an automobile, play golf, and have membership in clubs.

The business manager for doctors is a somewhat abhorrent idea to me. It seems the last word in commercializing the profession. Advance in medical science has been along the humane, and not the commercial line, and the great things in medicine have been done by individuals with a purpose. Still, the American people are running wild over organization. William Allen White said that if two Americans fell out of a balloon they would form some sort of a group before reaching the ground. In groups, too often, one or two big men who are outstanding are used for advertising purposes and then many small men to fill up. In groups there are always some men who have made their reputations outside the group, and with their reputations bring up the group standard. The group argument to employers may include more scientific service, but always does include cheaper medical service and saving of money. It has to be recognized that the financial prospects in industrial medicine are not always alluring. However, it is far better to have a fixed income under workmen's compensation than to have to send bills to injured and out-of-work employes who are unable to pay. The charging of the cost to industry, either directly or through insurance, is so sound that some of us wonder why it wasn't seriously thought of long before a short decade ago. The discerning doctor would strongly oppose a return to the old way of doing business. He recognizes that whatever benefits society places him, in the long run, in a position where he is the gainer.

Another factor in giving emphasis to the doctors' status in industrial medicine came out of the World War. Surgery for war wounds and surgery for peace wounds are not dissimilar—in fact, their genesis is the same. The quick attention, the instant use of the surgeon's instruments—these and other responses to urgent needs become reflected in fewer casualties and more repaired human beings. It has been recognized that the more specialized the treatment, the more dependable the outcome. This naturally followed the experience that can only come from doing the same class of work over and over and meeting the exigencies of such work.

So out of the horrors of war has come an appreciation of the relationship of war and peace in destroying or marring human beings. The purpose to restore one group to efficiency in order to fight can be followed to an even better end by planning to place the second group back into employment to resume their positions.

There can be no finer contribution to society than speedily to return to their occupations those who, unfortunately, are overtaken by industrial catastrophies. This gives the industrial doctor a unique status. If he is big enough to grasp his opportunities and follow the gleam, he will have the real satisfaction that follows work well done.

There are several outstanding factors or essentials that apply to the doctor in industrial medicine.

First—He must know his business. Absence of ability, of technical knowledge and failure to have learned from experience, leave behind in their wake too many losses that cannot be overlooked. This is especially so in industry, because society has laid down well-defined obligations for the treatment and care of injured workers, and the personal relation of doctor and patient has added to it a state dictum that is mandatory in character.

Second—The doctor in industrial medicine needs a human understanding, a healthy outlook on his fellow-citizens. He should realize his position is more than the one generally assumed between doctor and patient. He should realize the importance of winning men by fair treatment, by taking them into his confidence, so far as is possible, and by instilling into them self-reliance and respect for themselves.

Third—Care must be taken to eliminate the least taint of the charity idea in connection with surgical and medical treatment. Industry pays the bills, including the doctors' bills, but the hurt men make the painfully definite contributions of arms and legs and eyes and sometimes of life itself. The doctor must avoid any appearance of indifference or superiority to these generally super-sensitive patients. The injured man deserves a certain uniform courtesy, and he is sensitive to sympathy, which is valuable if of the wholesome type.

Fourth—The doctor in industrial medicine needs to keep up with the best in his profession, to find out the superior practices of others and to willingly give whatever may prove of gain in securing the great purpose of repairing the injured. He must be a student of prevention of disease and a follower of safety first in order to aid in the prevention of accidents.

The final test of an industrial surgeon is the value of the service he renders. The capacity of the industrial physician to serve is measured by the man

himself, his preparation, his vision, and, most of all, his attitude towards his job.

391 Sutter Street.

DISCUSSION

ERNEST CLYDE FISHBAUGH, M. D. (Pacific Mutual Building, Los Angeles)—Doctor Glaser has emphasized many of the salient features in the successful utilization of the doctor in industrial medicine. The doctor in industrial medicine is here to stay. Many physicians in California have already specalized in this branch of medicine. Others will have to give greater study and preparation for industrial work or be supplanted by more capable men.

The small compensation permitted by the state does not permit most physicians to specially equip themselves for this branch of practice. The small remuneration requires the employment of underpaid and ofttimes poorly trained assistants.

The business manager is obnoxious to many progressive and successful practitioners, but the definite remuneration is ofttimes most attractive to the poorly trained and less successful physician.

The personal qualifications as so admirably stated by Glaser are essential to the successful practitioner of industrial medicine.

This paper is timely and more such communications should be encouraged in order to advance the status of the present day industrial specialist.

PHILIP STEPHENS, M. D. (1136 West Sixth Street, Los Angeles)—The tendency toward commercialism in all phases of the industrial question is strong, and growing stronger each year. Groups, or so-called "service corporations," which are rapidly appearing in the field and competing with each other for business, are using, I am sorry to say, methods for fighting competition which apparently tend to squeeze out the individual industrial surgeon and his personal contact with the working man.

Doctor Glaser's plea for the old ideals, with their human touch, which under any and all circumstances must be preserved, is timely. We must preserve these ideals if we wish to hold the respect of ourselves, and all who must necessarily be served, and this great and good compensation law.

The traumatic surgeon or the general surgeon doing traumatic work must necessarily, under the present compensation law, get most of this class of work from either the industrial employer or the insurance carrier, and it behooves the industrial surgeon with special training along these lines to be a better general surgeon fundamentally, and the general surgeon to strive for more adequate knowledge and practice necessary to care for the injured man.

Many a good general surgeon falls far short in his effort to treat the industrial case, by reason of his failure to recognize certain fundamental principles, incident to what we might term ordinary routine, so absolutely necessary to make industrial work successful. They do not, and apparently will not, furnish accurate descriptive, anatomical records and reports of cases. Added to this is a total disregard for necessary promptness in rendering report at time of accident, with promptness thereafter in reporting progress of the case.

Another failure, as Glaser has cited, is due to the surgeon's lack of human touch with his patient. It is absolutely necessary for him to get the viewpoint of his patient, and he must use rare tact and judgment in the handling of this maimed and injured one who is making his sacrifice in the great onward rush of progress.

Doctor John Moorehead has said of the traumatic or industrial surgeon that he has long been of the opinion that cases of injury have not received the same care and attention accorded other surgical patients, and has often realized that a properly treated Pott's fracture or infection of the hand is a far greater manifestation of surgical art than the successful removal of an internal appendix.

E. W. CLEARY, M. D. (177 Post Street, San Francisco)—Doctor Glaser has given us a valuable paper. The doctor in industry should be a specialist in understanding and knowledge of the problems peculiar to the medical care of workmen. There is, however, nothing in the position of the doctor in industrial practice which justifies his considering himself sort of super-specialist. The oculist, the physician, the dermatologist, the neurologist, the urologist, the orthopedic surgeon and, in a lesser degree, other specialties in the field of medicine should be recognized by the doctor in industry just as readily as if he were in private practice. A doctor may specialize in industrial practice and, at the same time, be well qualified as a specialist in any one of the above fields, but not in all of them at the same time. There is no greater menace to proper standards of industrial practice than the doctor in industry who treats every patient himself.

At this time the field of industrial surgery is particularly menaced by a pernicious type of organization which is aimed not at the achievement of any high degree of efficiency of treatment of the injured, but at the control of a large volume of work. The promoter of such an organization usually derives a profit from the activities of a corps of hack-workers whose handling of the injury is likely to be devoid of sympathy and low in efficiency. Such promoters contend that their position toward their hired staff is similar to the ordinary and time-honored relation of the chief to his assistant. The relations are, in no true sense, analogous. It is true that the chief pays his assistant a salary and charges the patient for the assistant's services, but the assistant has a very valuable additional compensation in the teaching which the chief gives him out of the wisdom of his more extended experience. The patient, too, is better served where he gets the benefit of the quick keenness of the younger man and the mature wisdom of the elder. The dealer in industrial medicine brings to his hired staff no valuable teachings. The doctor on such a staff gets nothing but his salary, and the patient gets, as a rule, a perfunctory service, because the man who renders the service gets less pay for it than even the small fee which the industrial schedule allows.

Wherever sharp business practice has lowered the fee of the doctor who actually serves the patient, whether such reduction of fee be by directly cutting the price below the accepted schedule or by diversion of a part of the recognized fee to an organizer or promoter who does not serve the patient, industrial surgery is degraded and the patient is wronged.

Glaser has mentioned the important results of the war surgery. There is at present a deplorable tendency on the part of many doctors in industry to ignore the better methods taught by the war experience wherever these methods are more expensive and time-consuming. I agree thoroughly that, granted proper training, the most important question concerning the doctor in industry is his attitude toward his job. Whatever his special field of experience, no doctor should take up industrial surgery unless he is willing and able to make industrial surgery a major consideration.

Finally, although the peculiar situations which occur are often difficult to handle and sometimes embarrassing, there is nothing in the relations of the doctor in industry which either justifies or makes necessary a departure from the proven and time-honored ethical standards of his profession.

C. W. CLARK, M. D. (San Anselmo, California)—The paper by Doctor Glaser is worth the earnest consideration of all physicians and surgeons of our state and nation, as industrial medicine is here to stay. Under present conditions the employer must protect himself, and the wage-earner must be protected, so compensation insurance has made adequate protection for both possible.

All goes well until the accident happens, then the physician is called. He then must decide the issue with the unfortunate one, as a physician to the patient; but, on the other hand, he must make detailed reports to the insurance carrier and compensation boards (details distasteful to the busy physician).

As the case progresses reports are constantly being required. These reports of necessity require time to fill out. The compensation is not sufficient for the best men to bother with. So in the course of events, the poorly trained, the back members and the unscrupulous doctors take up the industrial side of medicine. They make out

reports and care for cases, or hire it done as if they had no interest in them.

The innocent victim resents this and, in turn, goes to his own physician, or he may go to some cultist, and the treatment he has received is reflected by him upon the profession at large, thus making a bad impression.

The cold commercial side of industrial medicine is not pleasant to most scientific men, so the best men in industrial medicine must not shirk, but assume the responsibility as any other. They must render the best possible service with the aim in view of getting the injured man back to work as soon as possible with the minimum of disability.

Carelessness and ignorance in treating injuries cause much more suffering and loss of time than is necessary in many cases. Thus, the insurance companies soon discover where they get the best service, and the unfit company doctor will, no doubt, soon be replaced by the specially trained industrial surgeon. There seems little doubt but that this will be developed into a specialty, as the others, in the very near future.

RADIOGRAPHS OF THE HEAD IN CHILDHOOD FROM THE CLINICAL STANDPOINT

By H. Douglas Eaton, M. D., *Los Angeles*

Radiography of the head in childhood is a valuable aid in diagnosis, both in chronic neurological and accident cases.

Up to the present time erosion of the sella is the only well-established evidence of pituitary disorder.

Roentgenologic evidence of pressure does not satisfactorily correlate with clinical findings.

Discussion *by E. B. Towne, San Francisco; Cecil E. Reynolds, Los Angeles; R. G. Karshner, Los Angeles.*

During the last three or four years we have been making radiographs of the head in all children referred to the neurological department of the Children's Hospital in Los Angeles. The cases radiographed include both outpatient and inpatient cases, irrespective of a history of accident or injury. A comparison between the x-ray picture and the clinical findings has been undertaken, with the hope that it might lead to something of value, either in diagnosis or treatment. This paper is an analysis and discussion of our findings, and is to be considered as a preliminary report. Many interesting leads were opened up which will be the subject of further study.

The x-rays were reviewed and diagnosed without reference to or any knowledge of the clinical history of the case. The evidence seen on the x-ray plates was then correlated with the clinical records.

Roentgenology of the skull is a form of investigation, an aid in neurological diagnosis, that has advanced greatly in use and in value in the last few years. Prior to this time, the technical difficulties in taking satisfactory pictures, particularly in children, interfered with the use of this procedure.

The early radiographs of the skull were directed principally toward an attempt to study the sella turica. Oppenheim first called attention to the possibility of this work in 1899, and noted the changes produced in the sella by pituitary growth. Other early workers, as Erdheim, Kohler, Jaugeas, Fuchs, Beclere, together with some English workers, notably Holland, continued this work. In 1912, Harvey Cushing gave a complete discussion of radiographs of the sella in his work on the pituitary body and its disorders. Fearnsides, Keith, Gilbert, Scott, Finzi, Hampson, Johnson, and Schuller, as well as Heuer, Dandy, and Carr, have also written extensively on the subject.

During the last few years, while these special studies have been continued, there has been an increased appreciation and study of radiography of the skull as a whole. In the present paper, Schuller's classification, as found in the English translation of his work by Stocking, has been used. In our series of cases, however, the variety of recognized lesions was found to be much less than those included in Schuller's classification. The pictures were taken at a tube distance of approximately twenty-two inches and an exposure varying somewhat on account of the child's movements, but about two and one-half seconds. All the patients were under 14 years of age, and a great many of them under five, so there has been considerable difficulty in taking satisfactory pictures. No ventriculograms are included in this study. In all, 207 x-rays of the head were taken, and 101 of these, or roughly 50 per cent, we felt should be classed as normal skulls, from the radiological standpoint. All authorities, as mentioned by Schuller and Pacini in their review of skulls from the anthropological standpoint, recognize the fact that normal skulls show marked variations in size and shape. As guides to our estimation of size and shape, the relation of the fissures and the proportion between the vault and base were used. The writer does not feel competent to discuss Pacini's work on angles, in relation to the sella turcica and pituitary disorders which was published in 1922 and for which he received the Leonard Research prize. In a review of the literature, however, many competent observers have been unable to confirm his work.

Anomalies, in shape and size of the skull, may occur as the result of disturbances in development. In our present series we found nine such cases, of which five were actual defects; one of these only being due to surgery. In two of these cases the records were incomplete. Of the remainder, four were girls and three were boys. Four of the cases showed extra sutures, in the frontal or parietal bones, without clinical symptoms. Two cases showed clinical evidence of increased intra-cranial pressure; a meningocele with an associated spina bifida and a megalocephalus, hydrocephalic type, also showing a meningocele.

Ten cases of size and shape variations produced by disturbance in growth, this disturbance in its turn due to anomalies of the contents of the skull, were found. Three of these were microcephalies, seven megalocephalies; the latter, with one exception, associated with hydrocephalus. Two of the three microcephalies were associated with impairment of mentality; in the last case, a malnourished child of a year's age, the x-ray was taken as part of a rachitic study. It is probable that this patient was also deficient. The megalocephalies were of interest only in confirming other observers that the cause of this condition is practically always hydrocephalus. All these patients showed evidence of pressure clinically, indeed the x-ray was of only confirmatory value in the diagnosis. The seventh case of megalo-

cephaly occurred in a boy of six. Here the diagnosis was a tumor in the mid-brain region. This patient showed optic atrophy, increased pressure of the spinal fluid, severe headaches, and projectile vomiting, with absence of evidence of infection. Operative procedure and autopsy study were refused.

There is an interesting class of cases due to premature synostosis of the skull. Various authors use various classifications for this group. Pacini, for example, quotes Luceas as using a classification involving twenty-four varieties of shape changes due to this condition. It seems to the writer, on the basis of the present study, sufficient to group such skull changes under the three headings of dolichocephaly (long head); brachycephaly (short head); turricephaly (turret head), the latter preferable to the oxycephaly (or steeple head), which Sutherland and other writers have described.

Schuller quotes the following figures as normal for the obliteration of the sutures. The base at birth. Spheno-occipital at 13, facial at 30 to 35, and the remainder soon after 35, with the exception of the sagittal and coronal, which begin between 50 and 55. The cases in our series obviously show a great variation from these figures.

The definite etiology of this condition is not known. It has been suggested that it is the result of the pressure of the edges of the bone against one another, occurring in utero or during labor, or that it is due to a constitutional skeletal disease, such as rickets or syphilis. The clinical records of our cases do not warrant us in drawing definite conclusions on this point. Sutherland groups his cases as being congenital, acquired during the first few months, or acquired from the second to the sixth year, but throws no light on the etiology. In our series we found only three definite cases. One brachycephaly (or short head) and two turricephalies (or turret heads). One of the patients was a definite mental defective, with a possible mild hypo-pituitary syndrome. Another was quite a marked case of rickets, while the third showed a defect in the occipital region, with a meningocele, a habit spasm and two cervical ribs; this child was normal mentally. None of the cases were proved to be luetic.

Schuller's class of changes in the skull, due to habitual attitudes or soft tissue anomalies, seems to the writer impractical. In our present series, we did not suspect any cases of belonging in this group.

Deformities of the skull in systemic diseases do not appear to be easily recognizable from a study of the x-ray plates alone, the method pursued in our present study. We did not recognize a case of cretinism, Mongolian idiocy, chondrodystrophy, or disotosis, which are the first four diseases listed by Schuller in this group. Rickets, we only felt sure of in two instances from the plates alone. It is to be recognized that our estimation of the age of the patient was from the plates, and that some cases would have unquestionably been called rickets, had we known the actual age. Schuller's other two headings of dwarfs or giants were not present in our series.

Turning to anomalies in the structure of the skull, we find our first group to be inflammatory conditions of the skull bone itself. We found no cases of active osteomyelitis in our series; there was one case which seemed definitely luetic, though the child had a definite acute osteomyelitis elsewhere. No cases of tuberculosis of the cranium were recognized. One calcified area was found in a left temporal lobe associated with the clinical picture of a mixed, but largely sensory aphasia. The parents of the child refused further investigation, so the final diagnosis was not made. It is possible this may have been a calcified solitary tubercle. The literature indicates that tuberculosis and actimomycosis of the cranium are both rare conditions, while acute osteomyelitis occurs most frequently after wound infections.

Schuller's atrophic and hyperostotic changes in the skull were not found in our series, as is to be expected, for we studied only children's skulls. Acromegalic changes were also lacking in our series. Schuller further mentions neurotic atrophy, a condition with changes in the skull and skeleton he considers due to a trophic nervous disease. Other observers consider such a condition of little importance. Basilarinvagination is another rare condition reported. This is said to be caused by undue weight of the skull added to improper development of the atlas or some nutritional disturbance in the bone surrounding the foramen magnum. The result is distortion and atrophy of the base of the skull. Virchow and Grawitz considered the etiology of this condition to be rickets, osteomalacia, or possibly hydrocephaly, but states there must also be a congenital anomaly in the formation of the skeleton. No cases of this sort were recognizable in our present series.

Tumors of the skull may be those involving bone or soft tissue. In our present series, five cases were found; all proved soft tissue growths save one. This case was in all probability a soft tissue growth, but operative and autopsy procedures were refused.

It is of interest to note that four out of five cases occurred in male children. In all five of these cases, the x-ray picture was of only confirmatory importance. Each case showed definite clinical evidence of increased intra-cranial pressure, and had focal symptoms.

Changes in skull structure may also be caused by injury to the skull. In our present series we found eight such cases. In all the cases but one, there was a definite history of an accident; the one exception was a child of eighteen months, and it seems probable there had been an unnoted injury. In fracture cases, radiographic study is of distinct importance, both in diagnosis and in the determination of treatment. In 4 or 50 per cent of these cases, we found so-called general erosion or convolutional atrophy markings—two generalized, one occipital only, and one frontal and occipital. Two we called first degree, and two second. The ages of these cases were: First degree, four and five; second degree, six and nine. We will discuss these findings a little later.

As we mentioned early in our discussion, a great deal of work has been done on the radiographic study of the sella. Spurred on by the hope of being able to recognize disorders of the pituitary, numerous writers have discussed varying methods of technique, and have drawn what seems to the writer

decidedly overenthusiastic conclusions from questionable evidence.

Obviously, the determination of variations from normal must be preceded by a determination of the normal. In the recognition of a normal sella, we find widely differing opinions. Someone has said that all scientists are divided into two schools—the "lumpers" and the "splitters." This certainly seems true in regard to descriptions and classifications of the normal sella. The "splitters'" school has listed some seven hundred type variations; the "lumpers," three. The writer prefers the "lumpers" for the purposes of the present discussion.

Gordon and Bell conclude that there is no definite shape of the sella in normal children. These observers attempted to classify the sellas examined into three shape groups, but not only found it extremely difficult to fit a majority of cases in these groups, but note that the groups, when determined, are of no clinical value. The same writers conclude, as the result of their study, that no definite relationship exists between the size of the head and the size of the sella. They did find the sella in girls to be larger in both height and length than in boys. They also found a fairly definite relationship between height and length, and noted that the most rapid growth in the sella took place in the first and second years. I have quoted their findings at length, for they seem to me rational and based on satisfactory evidence. Knox, writing recently in the British Journal of Radiography, on the other hand finds a definite relationship between the size of the head and the size of the sella. His apparatus is most elaborate, and the opportunity for technical error is so great that the writer questions the value of his conclusions.

In our present study we did not attempt any elaborate measurements or shape-grouping, for the reason that we considered them valueless. We grouped our cases as (1) large, (2) small, (3) closed in, the latter being the type where the anterior and posterior clinoid processes seem to roof in the sella; here, of course, the angle at which the plate is taken is of great importance.

Of large sellas, we found eight. In contradiction to Gordon and Bell, all of these but one were found in males. The age incidence was from four to twelve. Six of the cases were between eight and twelve. Two of the eight cases were classed as idiopathic epilepsy; there were three cases of brain tumor, one of multiple exostosis; one of epilepsy due to birth injury, and one of hydrocephalus. No signs of erosion of the sella were found in these cases. Inasmuch as these sellas showed a general enlargement, the possibility that they were simply broadened by pressure seems to be ruled out. In this group of large sellas, no evidence was found of relationship between the size of the sella and the clinical picture.

In the small sella group, we had six cases, evenly divided between the sexes. One of these cases was a normal child, studied on account of an accident. One case had a sixth nerve paralysis, etiology unknown. The other four cases were deficient mentally, one a hydrocephalic, one a hemiplegic, and one seemed pretty definitely a hypopituitary case, complicated by an evident birth injury and spastic paralysis.

Our so-called "closed in" groups consisted of ten cases, again equally divided between the sexes. The age varied between two and eleven, with no definite age incidence. Five out of ten of these cases were definitely deficient, two were classed as idiopathic epilepsy, one had a fractured skull, but otherwise was normal. One was a case of encephalitis lethargica, and one a case of progressive muscular dystrophy. Six of these cases showed definite clinical evidence of increased intra-cranial pressure, four showed signs of focal irritation. Only one of these, an imbecile, showed signs of deficient pituitary secretion. Surely, from the clinical standpoint, large, small, or closed-in sellas, cannot represent any definite pituitary syndrome.

It is to be noted further that, of 207 heads studied, only twenty-four, or 11 per cent, showed sufficient variation in the sella to be considered remarkable. Of these twenty-four cases, 2 or 8 per cent showed clinical evidence of pituitary disorder. Possibly this means that there is a relationship between abnormalities in bony structure and disturbances in the gland. I do not feel, however, that we are justified in any conclusion at the present time other than that evidence of erosion indicates tumor growths. Clinically, these cases, with several others showing clinical evidence of pituitary disturbance, have been treated with pituitary by mouth and hypodermically without results.

Schuller recognizes many possible causes for calcification in the skull. Aside from one case already mentioned, possibly tubercular in origin, no cases of calcification occurred in our series. Calcification in the pineal gland has occurred infrequently in my adult cases.

Changes of the skull, in consequence of intracranial disease, occurred but once in the present series. In a probable slow-growing mid-brain tumor previously described, there was some circumscribed thinning, with evident absorption of bone.

Under changes in the skull, due to chronic excessive intra-cranial pressure, Schuller mentions the following: generalized erosion, commonly spoken of as convolutional atrophy, shape changes, widening of the sutures and venous canals, and thickening of the skull. Chronic hydrocephalus, tumors, cysts, tubercles, gummata, are the usual diseases causing erosion of the inner surface of the skull. Diseases causing a rapid increase produce, in Schuller's opinion, roughness unrecognizable by radiography. A slow increase in the contents of the skull produces a mottling with numerous roundish light areas, local or generalized. These markings are said to appear within a few weeks of the onset of clinical symptoms, and in childhood are said to be seen earlier and to a greater degree. Schuller's conclusions in this regard are quite sweeping. He states: "Roentgenologic proof of erosion of the inner surface of the skull is a sure sign of an increased intra-cranial pressure which has existed for a long time."

In our study of this phenomenon, we were forced to some sort of classification, and consequently grouped our cases as showing first, second, third, or fourth degree of general erosion. It is realized that such a classification is an arbitrary one, but as all

the x-rays were re-read in two sessions, it is felt that the readings were reasonably consistent.

In our first degree series there were twenty cases in which we had complete records. Of these, eight were girls. There was no particular age-grouping. The cases ran from two to nine. Twelve were between five and nine. Eight of the cases were mentally deficient; two were retarded. Three were fractures occurring within ten days of when the plates were taken. The remainder showed varying degrees of birth injury or epilepsy or both. These clinical findings are not incompatible with Schuller's idea of increased pressure. It is to be borne in mind, however, that over 50 per cent of our x-rays did not show the convolutional markings to any degree, yet their clinical diagnoses ran practically the same as those in this first degree convolutional pressure group. Three of these cases were proved to have increased pressure clinically.

Our second degree cases numbered twenty-three, fourteen males. Twelve of these cases were definitely deficient, there were three fracture cases and, curiously enough, one rachitic case. A progressive muscular dystrophy, a dysuria, and a cervical Potts seem out of place in an increased pressure grouping. Six of these cases showed clinical evidence of increased pressure.

The third degree cases numbered eight, of whom seven were boys. Only two of these cases rated mentally deficient, another case of rickets occurred, there was one recent fracture, a cervical Potts, a brain tumor, and a hydrocephalus. The other case was a habit spasm with a double cervical rib. Five of these cases showed clinical evidence of pressure.

Our fourth degree cases, of whom we had complete records, numbered but three, all boys. Two of these cases were brain tumor cases with clinical evidence of generally increased intra-cranial pressure, as well as signs of focal irritations. The other case was one of osteomyelitis of the tibia. In this case clinical evidence of pressure—indeed, of head disturbance—was lacking as far as our records go. The age incidence in the last two groups did not vary from that in the first and second.

It is suggested to the writer's mind that convolutional markings, so-called, cannot be explained solely on the theory of increased long continued pressure. General nutritional changes seem a possible etiological factor which it is hoped to investigate more fully in a further study.

Shape changes, apparently due to increased pressure, were rare in our series. Only one such case was noted—a male child of three months, who had pyloric stenosis. This case also showed suture changes, but clinically gave no evidence of increased intra-cranial pressure, if the vomiting was to be explained by the pyloric stenosis. No neurological study was made of this case.

Changes in the sutures occurred in eleven of our cases. Thickened skulls in seven. Widening of the venous canal was found in twenty cases. Widening of the venous canals and suture changes were found together in but three cases, while in none of these cases were more than two of Schuller's signs of generalized increased intra-cranial pressure found in the same case.

The clinical findings did not correspond very satisfactorily with the x-ray evidence. For example, in the class of widening of the sutures there were six cases out of twenty who presented no evidence whatever of any increased intra-cranial pressure or anything remotely allied to it.

In the thickened skulls, one case was a normal child at least as far as his head was concerned. Suture changes seemed to be more constantly associated with mental conditions, for in this group every case but one showed mental symptoms. This one case was the one previously mentioned which was diagnosed as pyloric stenosis; it seems possible that a brain condition may have co-existed. The child did not survive, and no autopsy was permitted. Of the total number of cases in these last three subgrouping, namely, widening venous canal, suture changes and general thickening of the skull, thirty-nine in all, definite clinical evidence of increased intra-cranial pressure was obtained in eight only; clinical evidence of brain irritation or deficiency in twenty-three.

When the writer undertook this study he rather expected to reach some definite conclusions. The study has served, however, rather to open up interesting fields for further work in correlating radiological with clinical findings.

CERTAIN CONCLUSIONS SEEM WARRANTED

1. Radiography of the head in childhood is a valuable aid in diagnosis, both in chronic neurological and accident cases.

2. Up to the present time erosion of the sella is the only well-established evidence of pituitary disorder.

3. Roentgenologic evidence of pressure does not satisfactorily correlate with clinical findings.

I ask that you consider this a preliminary report, for there are many points which further study will, I am sure, elucidate. My deep appreciation is expressed to Rolla G. Karshner for his co-operation in this study.

1136 West Sixth Street.

DISCUSSION

E. B. Towne, M. D. (Stanford University Hospital, San Francisco)—Dr. Eaton's interesting paper brings up many points for discussion. I will confine myself to two x-ray findings, which are of importance in neurological surgery.

Eaton found in this series only one example of calification in the brain, and he has infrequently seen calcification of the pineal gland of adults. Our experience is quite different. R. R. Newell reported the findings of the Department of Roentgenology of Stanford University Hospital for the year 1922. There were nine cases of brain tumor which were microscopically verified, and six cases which were not verified, but which were, on the clinical findings and course, undoubtedly brain tumors. Six, or 40 per cent, of the fifteen tumors were localized by the x-ray because of calcification. Two of the calcified tumors were in children aged 6 and 10 years. Two other calcified lesions were demonstrated in children—a teratoma invading the cranium, and an inspissated abscess of the parietal cortex. Forty-five per cent of adults in Newell's series showed calcified pineal glands. Newell attributes the high incidence of pineal calcification entirely to improved x-ray technic.

I agree with Eaton that slight or moderate convolutional atrophy of the skulls of children needs clinical confirmation before it should be interpreted as indicating in-

creased intra-cranial pressure. I have observed several children who were suspected of having brain tumors because of epileptic attacks and convolutional markings, who have shown no further evidences of increased pressure after three or four years. The very marked examples usually do have other signs of pressure. The most advanced atrophies which we have seen have been in two 12-year-old boys; one of them had an extreme turricephaly, and the other an enormous meningeal tumor weighing 345 grams. Both of them had normal optic disks. I feel that marked erosion of the inner table of the soft cranial bones of children is a valuable sign, not to be discounted by negative optic disks.

CECIL E. REYNOLDS, M. D. (Pacific Mutual Building, Los Angeles)—This paper is of great value and interest in a somewhat neglected field. In my own practice, x-rays of the skull are taken almost as a routine, and out of a very large number I will direct my comments, especially to such as illustrate the points brought out by Eaton in regard to cases that are clinically most obscure.

In regard to microcephaly and synostosis, I adduced reasons for believing that many such cases were due to intra-uterine encephalitis or basal meningitis during early life. Either of these conditions will cause an excess of extracerebral fluid, with consequent shrinking of the cerebrum in the case of meningitis, the excess of extra-cerebral fluid being secondary in the case of encephalitis. In both instances there is a diminished expansile pulsation of the brain, which is a necessary factor in the proper development of the skull, and maintenance of the open suture. Benefit from operation in such cases can only be expected from differentiating the meningitic from the encephalitis and treating early. Primary encephalitis is obviously most unfavorable. In non-inflammatory cases, by the formation of new sutures, I first obtained benefit in 1912 (Southern Calif.: Pract: May, 1914).

The study of osteoporosis or convolutional markings is of great importance in epilepsy. It cannot be too much emphasized that the brain is apt to respond to pressure by fits when that pressure is insufficient or too intermittent to produce the coarse clinical signs of pressure. Most gratifying results have ensued in my experience from taking due note of the fact that x-ray reveals that a chronic pressure has at one time existed. Take, for example, occult hydrocephalus, a fairly common cause of so-called "typical essential epilepsy." If it remains "internal" it is most likely to show osteoporosis, especially when there is no pathological enlargement of the cranium. If it is primarily "external," no help will be given by x-ray, but many cases of external hydrocephalus have commenced as the internal variety, being later converted by a giving way of the tela choroidea, and these will show convolutional markings. Moreover, the fits of external hydrocephalus are more easy to diagnose clinically than those of the internal, hence radiography has a useful place in epilepsies from these causes where there is no enlargement of the skull.

In regard to the sella turcica, information may be obtained which is inaccessible in any other way. Two most striking cases will illustrate:

Mr. J. W. T. consulted me April, 1922, for petit mal with prolonged automatism since August, 1918. X-ray showed marked closure of sella turcica. He was fed on Burroughs and Wellcome pituitary, and had no attacks for a year after May 22, although before he sometimes had several a week. Then the gland extract was stopped and he soon after had an attack. Recommenced pituitary, and he remained well for another year, until it was stopped when he had another attack. He has remained well again since resuming the extract.

L. L. had severe whooping cough at the age of 7, and thereafter did not grow an inch in four years and had fits several times a week and clonus of the neck (nodding) nearly every morning. X-ray showed sella very enclosed and small. Pituitary extract had no effect. Suboccipital deduralization (complete) performed, and during the following year he grew a foot in height and has had no fits for two years. I do not attempt to explain this; it is interesting, in view of the very definite x-ray findings.

In regard to tumors, we have had some deep gliomas revealed by their slight calcification around the margins before confirmation by ventriculography. We have also found marked osteoporosis in some Mongolian defectives, but decompression in one such case was not followed by appreciable benefit. Very extensive calcification of the falx cerebri was revealed in one case with mental symptoms. In numerous cases changes of the membranes and local collections of fluid have been revealed.

From what has been said today, and from what has been written in the past, it is evident that there is a fertile field for radiography of the head beyond the more obvious manifestations of fractures and erosions by new growth.

R. G. KARSHNER, M. D. (1136 West Sixth Street, Los Angeles)—It is my privilege to have reviewed the radiographs upon which Dr. Eaton's paper is based. In many of the cases the failure to elicit pathology from these radiographs may be excused because of the technical inadequacy of the examination of the individual patients. The great majority of the radiological reports were rendered solely upon one or two lateral views of the head, not always of the best quality. Consequently, many of the examinations were passed as negative when careful radiography using an exacting technic with modern apparatus would have demonstrated changes from the normal. In other words, radiography of the head requires the expenditure of time and effort, which is not always compatible with the accomplishment of the volume of routine work that passes daily through a busy children's clinic somewhat handicapped by lack of direction, personnel, and equipment.

Eaton states that no case of cretinism, Mongolian idiocy, chondrodystrophy or dysostosis was recognized from the films. To my knowledge, more than half a dozen cases of chondrodystrophy have passed through the clinic, and have been diagnosed by the x-ray during the period covered by this series of cases. It is too well established that changes in the base of the skull in chondrydystrophy are demonstrable by the x-ray to challenge controversy. Failure to find such changes in this series is due to failure to include the cases in the series, or failure to make the proper roentgen examination of the head.

Dr. Towne mentions the report of Dr. Newell, regarding calcified pineal glands. In our private work we have noted a decided increase in the incidence of such findings, due to the employment of improved technical methods which were not afforded in Dr. Eaton's series.

Dr. Eaton seems justified in his third conclusion. Certainly, the presence of convolutional markings in the heads of childhood are not in the light of our present knowledge of the same clinical significance as the same findings in the skull of an adult. Many explanations suggest themselves. The cause, however, does not as yet seem clear.

DOCTOR EATON (closing)—In closing the discussion, I wish to re-emphasize my previous statement as to the technical difficulties in our series. Since reading this paper, we have had three cases of chondrodystrophy recognized by radiography without access to the clinical records. The previous cases mentioned by Dr. Karshner must have been omitted because of imperfection in the head film.

During the coming year we are planning to continue the study, and hope to have some conclusive data on one or two of the questions opened up in the present study.

Nu Sigma Nu Fraternity (reported by Miley B. Wesson)—During the course of the recent meeting of the California Medical Association, five acquaintances discovered that four of the group were members of the Nu Sigma Nu Fraternity, and it was suggested that a dinner party be given. A notice was posted on the bulletin board, and the following twenty-four men assembled. The manager of the Lodge simply pushed tables together and selected from the regular menu card a dinner which I have never seen equaled at any banquet.

It was unanimously decided to make this dinner an annual feature of the state medical meetings. Those present were: Stanley Stillman, William E. Stevens, Harry Alderson, George D. Culver, Morton R. Gibbons, J. Marion Read, Carl L. Schaupp, Percival Dolman, Curtis E. Smith, John H. Woolsey, Miley B. Wesson, San Francisco; F. S. Dillingham, Peter O. Sundin, Los Angeles; C. B. Jones, Sacramento; A. M. Meads, Sumner Everingham, Frank S. Baxter, Oakland; Robert T. Legge, Berkeley; A. L. Brankamp, Banning; Joseph H. Shaw, Santa Rosa; Keith S. McKee, Bakersfield; D. H. Murray, Napa; Irvin H. Betts, Visalia; Fred R. De Lappe, Modesto.

THE INFERIORITY COMPLEX AND ITS PSYCHIATRIC SIGNIFICANCE

By HAROLD W. WRIGHT, M. D., *San Francisco*

If a child survives the periods of infancy, childhood or adolescence without becoming inoculated with the inferiority complex, what happens later has little chance of fixing such a complex to any serious degree.

The survival of the physically inferior now does not conflict greatly with the interests of the herd, for the complex modern world has a place for all of them in its industrial scheme, providing they are psychologically fit to cope with their environment.

In some instances this complex is only the result of lack of proper vocational guidance and the adolescent or young adult becomes a misfit in the busy world, with consequent discouragement and failure. There must be many cases of this sort.

Illustrative case reports.

Neuropsychiatry has now reached a crossroads or turning point in its development. Its field of work, although broader now, is being encroached upon more and more by psychologists who have no medical education, some of whom are very superficially trained in their own line, some actually charlatans.

DISCUSSION *of the type that brings out important phases of an important subject by Ross Moore, Los Angeles; Aaron J. Rosanoff, Los Angeles; Ray Lyman Wilbur, Stanford University; V. H. Podstata, Livermore; Christine M. Leonard, Los Angeles.*

SINCE the beginning of any social contact of human beings this complex has existed. It began as soon as man had the opportunity to compare himself or be compared with other men, as soon as the interests of one conflicted with those of another, as soon as one surpassed another in any way. Thus was fear and jealousy bred, fear of others and fear of self.

As time passed and human relationships, both in the family unit and in the larger unit of community life, became more difficult this complex became more subtle and refined into forms less obvious to the sufferer from it.

The survival of the fittest, in the physical sense, was secured, and the non-survival of the supposedly unfit was made sure by very primitive methods in the days of savagery and barbarism; but later on the unfit, in the physical sense of that term, have more and more been enabled to survive. The survival of the physically inferior now does not conflict greatly with the interests of the herd, for the complex modern world has a place for all of them in its industrial scheme, providing they are psychologically fit to cope with their environment. Consequently, it is no longer true that this complex is inevitably associated with physical inferiority; it now arises much more from post-natal psychological impressions.

This post-natal psychological causation can, and usually does, begin very early in life; in infancy or early childhood. If a child survives the periods of infancy, childhood, or adolescence, without becoming inoculated with the inferiority complex, what happens later has little chance of fixing such a complex to any serious degree. This complex must be considered as something inoculated into the child by parents, teachers or other adults, or by fellow-children. Because of the impressionability of a child, all later tendencies have their roots in the plastic years. This is but an obvious truism, though one which is frequently forgotten in favor of laying the blame for everything on heredity.

Naturally, such complexes can be induced in a variety of ways which may be summed up in such descriptive terms as excessive "spoiling" with inculcation of dependency on father or mother, unwise and needless repressions of natural and innocent activities, nagging and scolding, physical cruelty and unfair punishments, ridicule and unfavorable comparisons with other children, marked social inequality of opportunity, high-handed moral attitudes on the part of adults toward faults or habits in the sexual sphere without calm explanation and frankly helpful advice, pessimism and irritability in the home atmosphere which reveals to the child parental inferiority and failure. All these influences tend to induce depression and loss of initiative with lack of fearless and confidential relations between the child and the adult world. In some instances this complex is only the result of lack of proper vocational guidance, and the adolescent or young adult becomes a misfit in the busy world, with consequent discouragement and failure. There must be many cases of this sort.

Undoubtedly, children react differently to such influences according as they are constitutionally vigorous or not, according as they are naturally inclined to be introverted or extroverted, aggressive or shrinking in nervous makeup, physiologically speaking. Consequently, in the aggressive type the psychoneurosis, which grows out of an induced inferiority complex, will differ in symptomatology from that which occurs from the same cause in the introverted type. And so we have later on the psychoneurosis with paranoid symptoms or with criminal behavior representing a defense against inferiority, and the psychoneurosis with depression, anxiety, diffidence and withdrawal from healthy social contacts; or the psychoneurosis with symptoms of a very complete withdrawal from the conflict and a satisfaction in solving the personal problem through hysteria. As any of these phychoneuroses progresses or as some other factor comes into play to break down the general nervous resistance (a toxic, exhaustive, or an organic factor), there may develop a psychosis of the paranoid type, the manic-depressive type, the schizophrenic precox type, or the hysterical type. Thus we may consider that psychoneuroses and psychoses are sometimes phases in the progress of the same fundamental complex—stages in a long-standing disorder of the personality.

ILLUSTRATIVE CASE REPORTS

1. A male child of intelligent parents witnessed from infancy the frequent quarrels between his parents, the father being at times violently irritable, due to chronic physical ill health and financial strain. As the child grew older he was always aware of some impending disaster in the home, which usually had an atmosphere of gloom and anxiety. An example of fear, doubt and indecision over any new problem was set before him by the father, who also vented his irritability upon the child for any trivial thing, making him feel thereby that he did not amount to much, that he was stupid, etc. The boy grew to love solitude and to shrink from taking part

in social pleasures with other children because he felt depressed, and his ill-concealed depression was misunderstood by the other children who thought him unfriendly. As time went on he developed the habit in his turn of showing irritation at trifling events and of putting off decisions because of his lack of self-confidence. By the time manhood was reached he had no definite plans for his future career, was inclined to take the path of least resistance, often being moody and changeable in purpose. He felt that other people thought him queer, that others were unfriendly. Not being very robust in physical constitution, he became asocial rather than actively anti-social. Energies of a physical sort found no outlet in healthy sports, and being shy of women he had difficulty mastering the habit of masturbation, which began at adolescence. He was afraid to marry. So he drifted along in a routine occupation much beneath his natural intellectual ability and, of course, was not satisfied in his work. He was sensitive to the criticism of his fellow-workers and his superiors to an extreme degree, and also jealous of those who were more successful than he. Middle age arrived with a realization that he was still a failure, and by the time he was 48 he had a severe attack of depression resembling the involution type of melancholia.

2. A young woman gives the history of having been brought up to think that anything connected with the sexual instinct was most deplorable. In childhood her first questions about such matters were side-tracked and received by her mother with embarrassment and evasion, also rebuke. As she matured she became very shy of boys, but her curiosity and thoughts along sex lines continued quite active. She felt that her thoughts were very wicked and that she must be different from other girls, for they did not appear to be bothered by such matters and seemed quite at ease with boys. She grew more and more self-conscious and diffident in trying to express herself in the social world. Naturally, offers of marriage were slow in coming. However, after a time she became infatuated with an unscrupulous fellow who seduced her. This experience produced a profound depression with anxiety symptoms, followed after some weeks by an acute excitement in which she had delusions of persecution, spoke of herself as the Virgin Mary, showed flight of ideas with prolific talk, and had to be confined in a psychiatric hospital. There she ran the typical course of an acute mania and recovered with a residual state of emotional apathy and indifference toward her family, to whom she has not yet been able to adjust herself. There also ensued a certain lowering of her standard of morality.

Many more illustrations of this complex might be given if time permitted. We are all familiar with the fact that hauteur and reserve and also their opposites, undue familiarity and aggressiveness, may cover up a feeling of inferiority or inadequacy, and that supposed modesty and humility may at times be a cloak for "cold feet." The two cases reported serve to indicate that a psychoneurosis or a psychosis is a condition of gradual onset and progress, and may arise from preventable psychological causes.

PREVENTIVE WORK IN NEUROPSYCHIATRY

It is quite apparent that these disorders are productive of much unhappiness, friction and failure, to say nothing of more serious consequences. They affect adversely the home life and industrial life and all with whom the individual comes in contact. We who work in the field of neuropsychiatry have some workable knowledge of the mechanism of these disorders. Indeed we have quite a store of theoretical knowledge, and we can have a much greater store of practical information which can be made available to parents and teachers for prophylactic purposes, provided we continue to get at the roots of these disorders in all patients that come to us.

Neuropsychiatry has now reached a cross-roads or turning point in its development. Its field of work, although broader now, is being encroached upon more and more by psychologists who have no medical education, some of whom are very superficially trained in their own line, some actually charlatans. The field is also invaded by all sorts of religious cults and narrow-minded philosophers. On the other hand, the citizens who are more discerning are looking to the medical profession for a solution of the problems of crime and juvenile delinquency, and many educational problems. They are ready and eager for our assistance, and often expect of us the impossible; and yet we have much to give them which we do not make clearly available.

We may well consider at this stage in the development of our specialty which, by the way, is so broad that it is inappropriately termed a "specialty," where to place the emphasis in medical education and research; whether to give less attention to refinements in the diagnosis and treatment of organic nervous disorders which we know have already wrought permanent pathological changes and more attention to the early detection of functional nervous disorders and the early treatment of them by sound methods; or to neglect the psychopathology of children and adults while worrying over tables of height and weight and nutrition or the chemistry of the cerebrospinal fluid.

We might consider also how we may formulate our growing knowledge of functional disorders of the nervous system so as to make it helpful to parents, teachers, and college students. To a slight extent this is being done here and there. It is not to be expected that many medical students can be made interested in neuropsychiatry if their vision of future work in this field is narrowed down to the palliative treatment or passive care of the end-results of chronic organic disease; but if their vision can be enlarged further by presenting to them the dynamic, social aspects of psychiatry in an attractive way, there should be no difficulty in providing this field with enough well-trained and enthusiastic laborers.

870 Market Street.

DISCUSSION

Ross Moore, M. D. (520 West Seventh Street, Los Angeles)—It occurs to me to wonder whether the manifestations of the inferiority complex so clearly and broadly sketched by Wright are not after all really conservative.

I am not saying that they ought to be conservative. Theoretically they ought not to exist. In the future they will not exist practically because then there will be enough square pegs for all the square holes and square holes for the square pegs. Our growing knowledge will make this possible and our growing tax rate will make society demand it. For the present the psychopathically inferior will have to remain largely ignorant of his own inferiority and retire within his own psychosis.

Methods of training the handicapped child are fairly far advanced both in school and home. There is much enthusiasm in both places to help these unhappy ones. But there is no enthusiasm in the home when it comes to recognizing and admitting the poor material out of which the child is made. I believe this admission will be forthcoming only when we force its presentation and at the same time show more clearly the social means available for its proper handling.

Stressing heredity is still the important thing.

AARON J. ROSANOFF, M. D. (Westlake Professional Building, Los Angeles)—The inferiority complex probably plays a part in the mechanism of all mental disorders of a functional nature. It is strange that no one had chosen it as a topic for special emphasis and discussion, as Dr. Wright has now done.

It is always a difficult matter to distinguish clearly hereditary or inborn factors from acquired ones. Dr. Wright deserves credit for pointing out that one factor in the bewildering complexity of mental mechanisms, namely, the inferiority complex, is always an acquired one. The significance of this is obvious for the practice of mental hygiene.

Wright has said that the field of neuropsychiatry is being encroached upon by persons without medical training. He seems to regret this fact, and I am in sympathy with him as far as this encroachment is by incompetent or insincere persons, whether with or without medical training. But I rather welcome all possible participation by psychologists, criminologists, social workers, teachers, and others. In my opinion, without such participation the larger ends of mental hygiene can never be attained, as they are beyond the unaided powers of the mere handful of neuropsychiatrists; and this not only because they are a handful, but also because some phases of the work require training and specialization which is not a part of medical curricula or practice.

RAY LYMAN WILBUR, M. D. (Stanford University, California)—As a rule all of the children in a given family are exposed to practically the same conditions at home, on the street and in the school. It hardly seems complete to me to lay all of the stress upon certain happenings of childhood in the child that later on shows certain psychopathic peculiarities. *I have the feeling that the psychopathologists in working backward for explanations of their patients are apt to forget the ability of many individuals to throw off environmental effects that disturb those who are mentally tainted.* All young people have a difficult problem in getting on with the adults with whom they are associated. It takes a good deal of skill on the part of a child to understand just what the parents want, why they want it, and why they vary so in their demands. I cannot escape the feeling that while the inferiority complex is of great significance it is the individual rather than the experience that is the predominating factor in turning mental reactions in an abnormal direction.

Dr. Wright's paper strikes me as particularly interesting and of real significance in developing a proper approach to the problems of the neuropsychiatric individual.

V. H. PODSTATA, M. D. (Livermore, California)—The paper of Dr. Wright leaves with me three impressions:

First—A keen appreciation of the endeavor of Dr. Wright to impress upon the medical profession the great influence of the early surroundings upon the moulding of the child's personality. Much has been written upon this topic, but the body of the medical profession has failed to be impressed by the facts. A small proportion of the physicians in general practice has been unduly influenced by the extremists in the psychoanalytic school; hence, embryonic and infantile sex conflicts and complexes. The larger number of physicians either cling to the ultra-conservative views or are more or less bored with the entire topic of study of behavior. Wright's paper is practical and worthwhile to every physician seeking to be of service to humanity.

Second—The limits of the paper are undoubtedly responsible for his taking up the "inferiority complex" and not reaching out to cover the entire topic of the common prevailing depressive tendency. The "inferiority complex" is only one common expression of such depressive tendency. There are many fears, obsessions, doubts, worries, and anxieties growing from out of the soil of the fundamental depressive tendency which are not identical with the "inferiority complex." I trust that someone may concisely, yet effectively, present this "Multitude of the Unhappy."

Third—No physician will question that Wright did well in emphasizing environmental psychogenic factors. However, they are not alone in the capacity to produce a tone of depression or the actual feeling of personal inferiority. Also, among the psychic causes it need not necessarily be the early surroundings of the child. There are many unsolved problems carried by adult people like millstones about their necks, producing perceptible and prevailing mental depression, also a variety of feeling of inferiority. Some of these unsolved problems may have been repressed below the level of consciousness, but that is not necessary to make them effective. Among the physical causes, toxic influences and endocrine unbalance should be mentioned. In short, every case of "inferiority complex" is an individual case compelling careful study of both physical and mental etiology.

CHRISTINE M. LEONARD, M. D. (1401 South Grand Avenue, Los Angeles)—I was present at the time Dr. Wright presented his paper, and enjoyed it. We had found in our study of children at the Child Guidance Clinic that the feeling of inferiority is a large factor in behavior problems. We have noted inferiority complexes with physical, intellectual and social bases. The child frequently attempts to compensate, and failure in this often results in overcompensation and definite maladjustment. These children are often problems both in the home and in the school. Physically they feel inadequate and do not take part in play with their companions. Sometimes they will not fight, swim or enter into active games; they are unable to compete successfully with their classmates. Because of feelings of social inferiority, they often will not bring their friends to their homes to play.

In children who have inferiority complexes the sense of self-confidence and power is missing and we have developed then, either a quiet, depressed, perhaps sensitive and reticent child (introvert type), or an egocentric, overcompensated child who is perhaps the bully of the neighborhood (extrovert type). Are we not warranted, then, in uncovering this complex early and helping the child overcome what Dr. Wright so clearly shows in his paper to be a large factor in adult maladjustment?

Witter Water—This is a product put out by Witter Medical Springs, San Francisco. It is advertised as a remedy for "high blood pressure." The public is warned of the tragic consequences of this condition and given the usual line of testimonials, telling how Mrs. A. with high blood pressure and one foot in the grave took Witter Water and recovered. Among other constituents, Witter Water is claimed to contain nitrites and it is stated that this "undoubtedly accounts for its direct action in the reduction of blood pressure." Witter Water is also claimed to contain sufficient iodide to produce beneficial action. According to an analysis, the amount of sodium nitrite present in Witter Water is one and one-half grains per gallon, and for $30 the sufferer from high blood pressure would get approximately ten grains of sodium nitrite. According to the analysis there is seven one-hundredths of a grain of potassium iodide in each gallon of Witter Water. Thirty dollars' worth of Witter Water contains less than one-half grain of potassium iodide. Yet the exploiters seem to think that the sodium nitrite content and the potassium iodide content are something to talk about (Journal A. M. A., June 27, 1925).

ACUTE PANCREATITIS

By Clarence G. Toland, M. D., *Los Angeles*

Acute pancreatitis can be conveniently divided into three types: acute interstitial pancreatitis; acute suppurative pancreatitis; acute hemorrhagic pancreatitis—pancreatic necrosis or gangrenous pancreatitis.

The consensus of opinion seems to be that the cause of the acute interstitial form is extension of infection through the lymphatics from an acute inflammation in some neighboring organ, such as the gall-bladder, the appendix, or a duodenal ulcer.

Acute hemorrhagic pancreatitis is generally considered to be a distinct disease and is thought rarely to be infectious in origin.

The diagnosis of acute pancreatitis in any stage is very difficult.

We must differentiate between this acute disease and incarcerated epigastric hernia; acute gastric dilation; ptomain or mineral poisoning; angina pectoris; spasm of the mesenteric arteries; mesenteric thrombosis; ruptured aneurysm of the abdominal aorta; acute intestinal obstruction; acute hemotogenous infection of the left kidney; perforation of undescended retrocolic appendix; ruptured ectopic pregnancy and Pott's disease.

Discussion *by Dexter N. Richards, Oakland; A. R. Kilgore, San Francisco; William Henry Gilbert, Los Angeles; Herbert A. Johnston, Anaheim; E. T. Rulison, Sacramento.*

THE most serious of the acute abdominal diseases with which we, the surgeons, have to deal is acute pancreatitis. The symptoms are acute, the diagnosis is obscure, the treatment is radical, and the results are not satisfactory, many cases terminating fatally—about 60 per cent.

No one has been able to definitely prove the exact cause of acute pancreatitis, and as a result there has appeared a large mass of experimental work and speculation on the subject. A number of men have produced acute hemorrhagic pancreatitis by injecting various substances, such as bile or duodenal contents into the pancreatitic ducts, while others have worked out a lymphatic connection between the pancreas and appendix and gall-bladder. They have shown that infection could extend from an acute process in either of these organs through the retroperitoneal spaces to the pancreas. The pancreas is subject to the usual inflammations affecting parenchymatous organs, but it is unique in being affected by a special inflammation due to a chemical action or an enzymic activity. Therefore, acute pancreatitis can be conveniently divided into three types: acute interstitial pancreatitis; acute suppurative pancreatitis; acute hemorrhagic pancreatitis—pancreatic necrosis or gangrenous pancreatitis.

Unless the condition is marked, producing a large pancreas, acute interstitial pancreatitis is often not recognized. Not infrequently it progresses to suppuration with localized abscess formation—the acute suppurative pancreatitis. "In same cases of acute hemorrhagic pancreatitis the hemorrhage remains localized; in others it bursts through the serous covering into the lesser or greater sac, producing what is known as 'perforation of the pancreas.' In this stage fat necrosis is found." "In cases where the hemorrhage remains in the peritoneal capsule of the pancreas, secondary infection occurs later, producing a pancreatic abscess."

The consensus of opinion seems to be that the cause of the acute interstitial form is extension of infection through the lymphatics from an acute inflammation in some neighboring organ such as the gall-bladder, the appendix, or a duodenal ulcer. A lymphangitis of the interstitial portion of the pancreas results.

Acute hemorrhagic pancreatitis is generally considered to be a distinct disease and is thought rarely to be infectious in origin. The common cause is a retrojection of abnormal bile; that is, bile rich in salts, into the duct of Wirsung or to a retrojection of duodenal contents into the duct of Santorini. Either of these agents in the pancreatic ducts activates the proteolytic ferment, trypsin, resulting in digestion and necrosis of the parenchymatous cells, erosion of blood vessels, and hemorrhage.

In a recent study of 100 necropsies, Cameron and Noble have produced an obstruction in the common bile-duct by the lodging of a biliary calculus in the ampula of Vater. In 65 per cent of the specimens studied, they demonstrated that the biliary and pancreatic ducts were converted into a common and freely communicating system and proved the possibility of a reflex of bile up into the pancreas.

Woring of London believes that all cases of acute pancreatitis are due to infection, and the bacillus coli communis is nearly always the infecting organism; occasionally streptococci may be found. He believes, through the study of fifteen cases, there is little doubt that the primary source of infection is generally the gall-bladder or the duodenum. The infection is spread from these organs to the pancreas by the lymph vessels or by the pancreatic or common bile-ducts. We feel that in the majority of cases this is true.

Fat necrosis is present in all cases of acute pancreatitis except in the acute interstitial type. It is thought by most of the medical profession that fat necrosis is due entirely to the local action of pancreatic juice; but cases are on record in which the process has been found both in the pericardial and extrapleural fat, leading one to believe that fat necrosis may be attributed to ferments liberated by the diseased pancreas and circulating in the blood.

SYMPTOMS

The symptoms of acute pancreatitis may, for convenience, be tabulated as to Woring—pain, vomiting, rigidity of the abdominal wall, rise of temperature and pulse, cyanosis and jaundice, localized abdominal swelling, diastase in the urine and glycosuria.

The pain is usually very sudden, located in the epigastrium or left upper abdomen and in the left lumbar region, often radiating to the left shoulder, left flank and anterior lower chest. It is usually so severe and sudden as to cause immediate collapse. In Case 2 the patient was so shocked it was feared she would die immediately.

Vomiting occurred in all of our cases immediately, the vomitus containing the stomach contents and bile; nausea persisted throughout the attack until the operation was performed or, as in Case 2, the stomach distress continued until death.

Rigidity of the abdominal wall was noted in three of our patients during the first twelve hours except in Case 3, where it lasted for four days; finally the

rigidity disappeared except in the upper abdomen and on the left side near the left costal margin.

Temperature at first is subnormal, the pulse is rapid and thready during the first five hours, becoming fuller as the temperature rises.

Cyanosis is very marked, especially of the extremities and face; this, to our minds, associated with sudden pain as described above, is almost pathognomonic of acute pancreatitis. We have never noticed jaundice; however, many writers say in the less acute cases a very slight icteric tinge of skin may be noted.

Localized Abdominal Swelling—It is occasionally noted that a distinct mass is felt in the upper left abdomen, extending across the spine to a few inches to the right; however, this is noted in only a few cases. We found it in Cases 1 and 3. In Case 3 a distinct rounded mass extended into the lesser peritoneal cavity; also it was distinctly outlined by x-ray examination.

Diastase in Urine—Normal urine contains 10 to 20 units of diastase. In disease of the pancreas, associated with pancreatic insufficiency, the diastase may amount to 100 to 200 units. Woring says that many cases of acute pancreatitis show this increase of diastase; but often in the very acute cases enough time has not always elapsed between the onset of the disease and examination of urine for this to be manifest.

Glycosuria—The cases are often so acute and need such immediate attention surgically, that enough time has not elapsed between the occurrence of the symptoms and time of treatment for sugar to show in the urine. We found no sugar in any of our cases. However, Case 3, which we still have under observation and treatment, only this week showed 138 mgms. to 100 cc. of blood, showing a slight increase above normal.

DIAGNOSIS

The diagnosis of acute pancreatitis in any stage is very difficult. The most important thing to keep in mind is the onset of the pain, its character and localization, associated with a cyanosis of extremities and face; the increase of diastase in urine; occasionally glycosuria and a slight icteric tinge of the skin; however, many cases occur in which the signs and symptoms are not sufficiently pronounced at first or their character has been so obliterated by giving morphine, that a correct diagnosis could not be made except by exploratory operation.

We must differentiate between this acute disease and incarcerated epigastric hernia; acute gastric dilatation; ptomain or mineral poisoning; angina pectoris; spasm of the mesenteric arteries; mesenteric thrombosis; ruptured aneurysm of the abdominal aorta; acute intestinal obstruction; acute hematogenous infection of the left kidney; perforation of undescended retrocolic appendix; ruptured ectopic pregnancy; and Pott's disease.

Cases 1 and 4 belong to the group classified as acute interstitial pancreatitis. Case 1, secondary to acute appendicitis, Case 4 followed acute cholecystitis with stones.

Case 2, that of a woman 38, belongs to the type of acute hemorrhagic pancreatitis. No operation was performed because patient was too sick to attempt surgery, as far as we believed.

Case 3, a woman 41, belongs to the type of acute suppurative pancreatitis developing following acute cholecystitis with stones.

TREATMENT

The treatment of acute pancreatitis is always surgical, if the patient is not in extremis. Usually the sooner operation can be performed after the onset of the affection, the greater are the chances for recovery.

The greater sac of the peritoneum is opened and exploration immediately made. The pancreas usually feels rather soft; at times the color is cherry-red, again very pale. There is usually present in the abdomen a beef-broth fluid and fat necrosis.

After the pancreas is exposed, free incisions should be made into the swollen gland, usually parallel to the long axis of the organ. Drainage tubes are inserted down to the incised areas and the wound closed in the usual manner.

Case 1—Male, age 14, school boy. Referred to us March, 1922. Acute interstitial pancreatitis.

Present Illness—Following an attack of influenza, developed an acute perforative appendicitis with abscess formation. He was operated upon, the appendix removed, and the abscess drained. Aside from a troublesome cough, he made good progress and on the sixth day his temperature was normal. The next day the temperature began to rise and he noticed soreness in the upper right abdomen; the soreness gradually increased, and he soon developed a tender mass in this region. This mass steadily increased and resisted treatment, such as local hot applications. The thirteenth day the temperature was 104, and the pulse rapid and weak. Operation for a secondary collection, sub-hepatic or retrocaecal abscess, was decided upon. The laboratory tests showed normal urine; Hb. 70; R. B. C. 4,500,000; W. B. C. 20,000; and 90 per cent polys.

Operation—An incision was made to the outer right edge of the mass and a greatly enlarged pancreas was exposed. The pancreas was hard and tense and did not fluctuate. The capsule of the gland was incised to relieve the tension, and drainage tubes were inserted. There was immediate improvement in the boy's condition—his convalescence was smooth and rapid and in one week he was able to return home. At present, two years later, his condition is excellent.

Case 2—Female, age 38, housewife. Consulted us July 15, 1923. Acute hemorrhagic pancreatitis.

Present Illness—For about ten years has had attacks of what patient termed "stomach trouble," causing vomiting and occasional pain in the epigastrium. Six weeks previously, after eating an apricot, developed sudden acute pain which radiated over the whole abdomen; she vomited profusely and became distended. The symptoms persisted, and for five days there was no bowel movement. A doctor was called and an opiate given to relieve the pain. A profuse diarrhea developed which was very offensive. Her symptoms persisted unchanged for five weeks, at which time we first saw her. There was extreme emaciation; she was sweating and her limbs were cold; the abdomen was distended; had almost constant bowel movement; moderate tenderness in upper left abdomen and left flank. The pain radiated to the left shoulder and back. Past History—Operation for appendicitis, eighteen years ago. Physical Examination—Anemic, emaciated female in state of marked shock. Blood pressure, 120/70. Temperature, 101. Pulse, 140. Eyes showed dilated pupils. Considerable tenderness of posterior neck muscles with some rigidity. Rapid respiration. Lungs clear. Heart showed poor muscle tone.

Abdomen—Marked general distension from gas. Tenderness in epigastrium. No rigidity; no masses. Patient was sent to hospital. Laboratory tests showed negative Widal.

A diagnosis of diffuse peritonitis and acute pancreatitis

was made, but patient was too ill for operation. She was treated as a peritonitis case and improved somewhat. Continued to have frequent bowel movements with some blood; odor very offensive. On the fifth day she developed a profuse hemorrhage from the bowels and died four hours later, apparently from hemorrhage.

Autopsy showed an unusual condition. On opening the abdomen, the typical beef-broth fluid of acute pancreatitis was noted. There was fat necrosis everywhere; all the abdominal organs were acutely congested. No stones noted in gall-bladder nor common duct. There was a large retroperitoneal collection of blood and pus containing the pancreas free in the cavity. The lower left portion of the collection had formed a communication with the descending colon, and the colon was filled with blood and pus—Nature's attempt to evacuate the collection. Grossly and microscopically, the pancreas showed diffuse necrosis.

The autopsy diagnosis was acute hemorrhagic pancreatitis.

Case 3—Female, age 41. Referred to us September 10, 1923.

Present Illness—Well until ten years ago when she had a sudden attack of severe pain in the epigastrium; lasted about twenty-four hours and was associated with vomiting. Similar attacks two years ago and another six months ago; the latter required a hypo for relief. The last attack came on three days ago without apparent cause. There was sharp, cutting pain in the epigastrium followed by upper abdominal cramps. Took a saline purge, which was followed by vomiting, pain increased and required a hypo for relief. The acute pain recurred and has appeared at intervals up to the present. Marked tenderness in upper abdomen between attacks. The pain radiates to the right shoulder. Associated symptoms are meteorism, vomiting, chills, fever, and constipation. Patient feels very weak and ill.

Past History—Diseases of childhood. Malaria at 12. Menstrual history normal. Physical Examination. Anemic-looking female in state of moderate shock. Blood pressure, 120/50. Temperature, 101.3. Pulse, 98. Head, neck, heart, and lungs normal. Abdomen shows a tender mass in the epigastrium about the size of an orange; it is not movable; it pulsates and fluctuates on palpation. No bruit heard. Moderate rectus rigidity. Mass does not move with respiration and is dull to percussion.

Patient was hospitalized and treated by applying ice to epigastrium. Her condition improved for a week and remained stationary, when operation was decided upon.

Laboratory tests showed normal urine; negative Wassermann. Hb. 75; R. B. C. 5,000,000; W. B. C. 12,000; and 86 per cent polys.

Fluoroscopic by Dr. Granger—Tumor mass in the position of the pancreas, about the lesser curvature of the stomach and behind it, displaces stomach a little; not connected with stomach or intestines; may be inflammatory mass in the lesser peritoneal sac.

Operation disclosed an acute cholecystitis with distended gall-bladder containing many small stones. The pancreas was about three times its normal size, was hard and tense. There was an abscess in the midportion which extended into the lesser peritoneal cavity, and was attached to the posterior wall of the stomach. The abscess was exposed through the gastro-hepatic omentum, its wall sutured to the parietal peritoneum, and it was then opened. Drainage was maintained by iodoform gauze surrounded by gutta percha tissue. A cholecystostomy was then performed.

The convalescence was stormy, with chills and temperature up to 103. It was noticeable that her condition was worse when the gall-bladder did not drain and that she improved when the bile drainage was re-established. The symptoms gradually subsided, and in about four weeks she went home with a small opening in the upper angle of the wound discharging a clear serous, slightly irritating fluid.

At the end of three months the sinus closed. There followed immediately a distinct painful mass in the epigastrium. The mass was very tender and the patient, a nurse, was not able to follow her usual work. Several times the old sinus opened spontaneously, giving sudden and complete relief from pain; tenderness and the tumor disappeared completely. The sinus, however, would close again and immediately the former symptoms would return.

Five months after operation patient was re-operated for a tender mass in the pancreatic region. The former sinus had closed and could not be opened. The pre-operative diagnosis was "pancreatic cyst."

At operation a cyst was discovered, evidently involving the body of the pancreas. The cyst was about the size of an orange and contained clear fluid. Because of dense adhesions and its intimate relations with the pancreas, the cyst could not be removed.

The cyst was opened, the cut edges sutured to the edges of the abdominal incision, and the cyst cavity lightly packed with gauze.

Convalescence was uneventful, and patient went home in four days. She obtained complete relief from pain and at present is able to do her work as nurse, and has regained normal weight and strength. There is still a small packing of gauze in the wound and considerable watery drainage.

Case 4—Female, age 35. Present Illness—Three years ago patient complained for the first time of sharp pain in right upper quadrant which remained localized for a few hours. She had some nausea, but did not vomit; was feverish and had poor appetite. On November 30, 1923, patient had a similar attack; pain did not radiate, but remained localized in epigastrium. There was vomiting and considerable nausea. Between attacks of sharp pain the patient felt a distress in the epigastric region. There was no jaundice. Patient stated she had never been sick, but her bowels had been constipated for many years, and her appetite poor. Family history showed no tuberculosis, cancer, insanity, nor diabetes. Physical Examination—No abnormalities except moderate upper abdominal rigidity with marked tenderness; no mass.

Pre-operative Diagnosis — Perforated du. or subacute cholecystitis.

Operation—On December 1, cholecystectomy for acute cholecystitis was performed, and showed the gall-bladder about four times normal size, very white, great deal of edema. Marked edema of the mesentery of the transverse colon and omentum. Marked amount of beef-broth fluid in the abdominal cavity. Pancreas about twice normal size, but extremely soft. Exploration of stomach, appendix and spleen negative. A small cyst size of hen's egg right ovary, which ruptured on examination. Marked deformity of the cystic duct to the common duct—runs parallel with the common duct for about one and one-half inches.

Microscopic findings were subacute cholecystitis, multiple mixed gall-stones.

Recovery was uneventful. Profuse bile drainage at first with considerable abdominal pain, but each day showed less drainage and less pain.

Patient left the hospital December 19, wound clean and patient feeling well.

On March 1, patient returned for examination. She was apparently in good health, and there was no drainage from the wound.

Pacific Mutual Building.

DISCUSSION

DEXTER N. RICHARDS, M. D. (Medical Building, Oakland, Calif.)—My personal experience with acute pancreatitis has been limited and the correct pre-operative diagnosis has been rare. I would mention in the list of diseases to be differentiated from it, acute perforation of gastric or duodenal ulcers. The suddenness of onset. the severity of the symptoms leave little doubt that there has been an upper abdominal catastrophy.

Personal history aids in a differentiation, and the physical signs not characteristic of perforated ulcer or other acute diseases mentioned by Toland, leads one by exclusion to a diagnosis of acute pancreatitis—sometimes.

Immediate operation, exploration, is always indicated. Convalescence is often protracted and may end fatally after recovery seems to be in sight.

A. R. KILGORE, M. D. (391 Sutter Street, San Francisco)—One fact stands out from Toland's paper and from the reading of other articles stimulated by it—sudden, agonizing pain in the upper abdomen, accompanied by signs of

collapse, ought to make the abdominal surgeon put acute pancreatitis high in his list of differential diagnoses. Accompanied by persistent vomiting, absence of fever, and the presence of epigastric prominence, the indications are sufficiently definite to warrant examination of the pancreas first in exploratory operation.

It is equally clear that early operation is indicated. Balch and Smith reported eleven operated cases with three recoveries, and ten unoperated cases with one recovery. Several of their operated cases were not explored until from two to three days after onset, and one cannot help but feel that a 70 per cent mortality might have been reduced by earlier interference.

The operative procedure of multiple longitudinal incisions in the gland capsule and drainage through the lesser cavity and gastro-hepatic omentum seems well founded and standardized.

WILLIAM H. GILBERT, M. D. (Brockman Building, Los Angeles)—I am satisfied that inflammatory conditions of the pancreas—more or less acute—exist with greater frequency than we suspect. It is not unusual for "stomach trouble" to manifest itself for which we can find no definite cause, the attacks coming and going with irregular frequency. Pressure in the upper left abdominal quadrant will many times elicit pain in these cases, and they may be a low-grade type of pancreatitis. As a consequence, the pancreas, as well as the gall-bladder and appendix, is coming into its own as a causative factor in obscure stomach derangements.

Toland's paper in a masterly way calls to our attention that particular brand of acute pancreatitis which belongs among the explosive type of acute abdominal conditions and requires boldness and prompt surgical skill in handling.

Violent pain in the epigastrium radiating upward and to the left, with Arthur Bevan's "wooden belly" accompanied by a highly resistant left costal arch, persistent vomiting, and pronounced signs of shock with cyanosis of the extremities, are the cardial symptoms (if there be any) of this condition. It is indeed a question calling for rare surgical judgment and diagnostic acumen as to the advisability of operation with these conditions confronting one. That this is a surgical abdomen, goes without question. My own experience in two of these cases leads me to believe that surgical intervention offers the only rational method of procedure, and that it should be resorted to as soon as the physical condition warrants. The sooner the better, consistent with the well-established principle of non-surgical intervention, when shock is existent. On the other hand, unwarranted procrastination can only add to the already high mortality.

The procedure of multiple longitudinal incisions in the pancreatic capsule, accompanied by drainage, is the operation of choice, and I believe it to be the only method that holds out hope of lowering the high death rate that goes with these cases.

HERBERT A. JOHNSTON, M. D. (Clinic Building, Anaheim, Calif.)—During the last quarter of a century, diseases of the pancreas have received sufficient study that now the so-called "drama" of acute pancreatic disease is recognizable. It has been largely through the study of this organ, permitted by the surgical work performed on the gall-bladder, that its acute pathological processes are better understood.

Dr. Toland, in his estimable paper, emphasizes the importance of early diagnosis, though usually difficult. The sudden onset of upper abdominal pain, cyanosis of lips with pallor of face, and a tender mass in the pancreatic area are highly suggestive. A recent case operated upon here presented the following: Sudden, deep-seated, pain just above the umbilicus in a woman 24 years of age, six weeks after a normal delivery, and three weeks after an attack of mumps, the upper abdomen slightly rigid, and a diffuse tender mass palpable in the pancreatic region, marked cyanosis of lips, anxious expression and restlessness. At operation, twenty hours from onset, we found very marked fat necrosis, and more than a quart of the characteristic fluid in the peritoneal cavity. The pancreas was much enlarged and of a gray color. Tissues of the gall-bladder region were engorged and edematous. Multiple longitudinal incisions in the pancreas, and very liberal use of rubber drains relieved the acute condition. The patient's life was in the balance for weeks. The secretion of fluid seemed to be almost unlimited, and the condition of the skin, surrounding the incision, became unbearable. After ten weeks in the hospital, the patient was discharged in a very weak and emaciated state, but at present is improving and will recover.

E. T. RULISON, M. D. (California State Life Building, Sacramento, Calif.)—Dr. Toland states "cyanosis is very marked, especially of the extremities and face; this, to our minds, associated with sudden pain as described above, is almost pathognomonic of the acute pancreatitis."

Cyanosis must be due to sub-oxygenation caused by the spastic fixation of the muscles of respiration. That this important sign may be associated with acute epigastric pain and a board-like rigidity of the abdomen in a condition other than acute pancreatitis is illustrated by the following case:

In August of this year I saw, at the Sutter Hospital, a man who had just been admitted with a diagnosis of perforated duodenal ulcer. The patient was prostrated, distinctly cyanosed, skin moist, suffering excruciating pain in the epigastrium and left flank, abdomen of board-like rigidity; temperature subnormal, pulse 84; vomiting of the stomach contents had occurred. In other words, the patient presented the picture Toland has so clearly drawn of acute pancreatitis.

Careful questioning of the patient, however, brought out the following: At the time of the onset he had been seated in an outdoor toilet; the initial transitory pain had been in the glans penis, but an instant later was felt in epigastrium and left flank, where it persisted. Examination of the glans revealed a tiny lesion which about three hours later developed a transitory urticarial wheal. Cyanosis and abdominal rigidity disappeared after forty-eight hours, and pains shifted to extremities and slowly decreased in severity.

The condition was due to the bite of the most venomous of our American spiders, latrodectus mactans. Kobert has isolated a toxalbumen from this species which, if introduced directly into the blood stream, as no doubt occurred in the case cited, produces symptoms and signs which simulate closely an acute abdominal lesion. Death has been known to ensue.

The Treatment of Diabetes Mellitus in Children—While many adult diabetic patients can get along without insulin, A. Graeme Mitchell, Cincinnati (Journal A. M. A.), says that practically all diabetic children will be benefited by its use, the severity and progressive character of the disease in them making it difficult to give a diet that will keep them sugar and ketone-free while supplying enough food for growth and development. The diabetic diet for children should be planned with three definite factors in mind: (a) The protein content; (b) the relation between ketogenic and anti-ketogenic substances, and (c) the glucose tolerance of the patient. It may be assumed that a child will require at least 1 gm. of protein for each pound of body weight. Protein-containing foodstuffs are selected that will furnish this amount. Ketogenic food substances must be balanced against anti-ketogenic food substances. If the diet contains not more than 2.5 gm. of fat for each gram of carbohydrate plus each gram of protein, ketosis will not occur. In continuing the planning of the diet in which protein has already been supplied in the proportion of 1 gm. per pound of body weight, the remainder of the food must be added so that there is 1 gm. of carbohydrate and not more than 2.5 gm. of fat for each pound of body weight. Children are especially prone to the development of acidosis, and it is well to keep the fat lower than would be permissible in adults, not much more than 2 gm. of fat being allowed per pound of body weight. This is particularly important in initial diets until the glucose burning power of the body is known. Mitchell gives details for the treatment of uncomplicated cases—cases in which there is diacetic acid in the urine and cases in which severe acidosis and threatening coma are present. Children must be under close surveillance lest they supplement their restricted carbohydrate allowance in a surreptitious manner.

EDITORIALS

PRESIDENT MACGOWAN'S ADDRESS

Our much honored and beloved retiring president, Granville MacGowan, crystallizes the ripe experience and the meditations of a mature and remarkably acute mind in his presidential address published on page 833 of this issue. Doctor MacGowan raises a number of problems that every doctor has thought about and he gives us the benefit of his experience and judgment in the solution of some of them.

One of the most hopeful signs in our many-sided medical progress is, that more and more physicians are becoming actively interested in the broader, and probably the more important, problems of physicians as classified usually under medical economics, ethics, medical politics, and public health. All physicians admit that one of our greatest failings in the past consisted in devoting our talents too exclusively to bedside interest in sick people, thereby overlooking the necessity for carefully planned and homogeneous mass action in solving some of the broader problems that reflect upon communities as a whole and by which physicians en masse are more likely to be judged than by the striking individual successes of individual physicians in the care of individual patients.

"COLD SCIENCE, EFFECTIVE BUT NOT ALWAYS CONVINCING, has come into nursing and medicine, as sentiment has been squeezed out. It has been remarked that in the beginning medicine was all art and no science, while now we are trying to make it all science and no art."

There is a whole essay in the above epigram quoted from Edward N. Ewer's inaugural address as president of the California Medical Association (page 838). It was difficult to select this outstanding quotation from this unusually able and thoughtful address, every sentence of which has had the care and attention that makes literature—and authors. Our new president has something to say, and he says it in a way that makes light work for an editor and easy and profitable reading. His wholesome message should—and no doubt will—have the thoughtful attention of physicians individually and of organized medicine.

A WARNING!

In calling the attention of doctors to the upgrade tendencies of poliomyelitis, the California State Board of Health Weekly Bulletin says:

"In the weekly bulletin for April 11, 1925, attention was called to the undue prevalence of poliomyelitis. It was pointed out in that issue that poliomyelitis is ordinarily more prevalent during the early fall than during any other season of the year. Attention was called to the fact that experience has shown that, in those years when more cases than usual appear during the spring months, pronounced outbreaks of quite extensive proportions nearly always occur during the fall of the year. Since the publication of these statements last month, still more cases of poliomyelitis have appeared. About thirty cases have occurred in California during the past four weeks, as many as twelve and thirteen cases having been reported during separate seven-day periods."

"There has not been an extensive outbreak of poliomyelitis in California since 1915. *The present trend of the disease, however, indicates the necessity for providing every possible safeguard against an epidemic of the disease next fall.* Prompt reporting is essential, for this is the first and most important step in the control of this disease, and unless all suspected cases are reported and investigated without delay, the control of the disease is made extremely difficult."

The physician who is thoughtless or negligent assumes a responsibility that should cause him unhappiness—at least.

SOME PROBLEMS OF DOCTORS

"Dear Editor," writes one of our good doctors, "When you have time and opportunity, will you be so kind as to give us an editorial or other comment, telling us what is our duty, and what is our best policy in handling a certain type of case. This inquiry comes to mind as a result of two incidents that have happened to me; in order to make my request plain it will perhaps be best to relate these incidents in detail.

1. "Some months ago, I was asked by one of our leading men to see a case of diphtheria with a man who is a ——, although he has a P. & S. license. This proved to be a case of laryngeal diphtheria in a child of 8 or 9 years who had been under treatment for four days. No antitoxin had been given. I used very straight talk to the parents and I was successful in my argument, so that they allowed me to give 60,000 units, in spite of their religious opposition. I did not see the child again, but was told that he recovered from the local symptoms of diphtheria, but died four days later of heart paralysis. THE ANTITOXIN WAS GIVEN THE ENTIRE BLAME FOR THE DEATH. As a result of this occurrence, I resolved that in the future I would not be quite so positive in my arguments, but would state the case and let the parents decide.

2. "A few days ago, I was called to see a boy of 9 years who had had diphtheria six days without treatment. The parents said they wanted me only to make a diagnosis, *that they would treat the case.* I told them they were letting the boy die from neglect, and left it to them to decide. They said they would call me up later if they changed their mind. The culture from the throat was positive; also a smear taken at the same time. So, without waiting for the culture, the matter was reported to the health officer, who placed a quarantine on the house. Two days later an undertaker called me over the phone and asked me to sign a death certificate in this case. I refused to do so.

"The other day, while discussing the above with some of the other doctors, I was rather severely criticized by a man for whose opinion I have great respect. He told me that I did not do my whole duty; that I should have taken the matter up with the coroner at the time, instead of with the health officer.

"Since death resulted in each of these two cases, the matter is serious. If it were a matter of adults who were refusing treatment for themselves, I should not worry much, but as it was a child in both cases, I do not feel comfortable if I have not done all that was possible.

"I would appreciate, and perhaps others might also appreciate, a statement from you as to what one should do in such cases. If one urges the use of antitoxin and is successful in his argument, one is blamed for a death

if one occurs; if one urges the use of antitoxin and does not carry his point, he is guilty of neglect in the view of his confreres.

"Does the coroner, or any other officer, have the power to compel treatment of children in such cases?"

COMMENT

One of the oldest of known epigrams is to the effect that one cannot work in a stable without carrying the odor of manure. It is equally true that an educated ethical physician cannot consult with nor connubiate with a cultist—licensed or unlicensed—without attaching to himself the odor of cultism. Unquestionably, our correspondent, whom we personally know to be a competent physician of the highest integrity, made his first mistake in "seeing his patient" *with an inadequately educated "doctor."* It is true that too many otherwise educated, useful and often older physicians, some of them high in *popular* esteem, furnish examples of such unethical conduct in their relation with cultists. But all such men are either unbelievably stupid or mercenary beyond hope. Stupid, because no matter how deeply they think they have buried their heads in the sand, they fail to appreciate that their weird odors travel further and faster among their colleagues than do their virtues, be these ever so numerous and valuable. See your patient, yes, by all means, but refuse to recognize or consult with any cultist or so-called "doctor," even though licensed, who will treat a diphtheria patient for four days without using antitoxin.

It is difficult, it is true, to see an irresponsible child going to almost certain death with diphtheria, without having the marked advantages that all physicians *know* accrue from the intelligent use of antitoxin. Nevertheless, our correspondent was perhaps overly insistent, in view of the peculiar religious and medical beliefs and practices of the parents. It is well in circumstances of this kind to insist upon the presence of some other safe intelligent witness and follow-up worker—*preferably a reliable nurse.* And once having assumed the proper responsibility of administering antitoxin to an obviously desperately sick child, the doctor should have followed this step up by frequent subsequent visits. *This should have been one of the stipulations made before the antitoxin was given.* It is not enough to throw a lifeline to a drowning person; the service must be followed up.

Our correspondent's conduct of the second case was above reproach. Having very properly refused service under the conditions imposed and having reported the matter to the official public health authority, his duty was fully discharged. It was the duty of the official health department, once in charge with their yellow card on the house, and not that of the doctor, to see that justice was served, including a report of the matter to the coroner, if they believed, as apparently they had reason to suspect, that someone ought to be prosecuted for manslaughter. Our correspondent does not tell us *who did* sign the death certificate.

The trick of asking doctors to sign troublesome death certificates to protect incompetent cultists, self-medicators, and those fortunately rare parents who want to treat their own children, whether by prayer or pills, is an old one. Public health officials claim that too many doctors jeopardize their standing, and in several instances recently, their freedom, by acceding to such requests. Our correspondent expresses the universal sentiment of good doctors when he particularly deplores neglect, or worse, of sick children, but it is well to remember that the contractual relations between the personal health physician and his patient are private and, to a degree, privileged. Society has established and maintains public health services, courts and coroners to see that the interests of the state in the child are maintained, and to punish when necessary. It, of course, is the duty of the personal health physician to report such matters as he mentions to the public health authorities and it is wise to do so in writing, retaining a carbon copy of the letter. Of course, no harm is done and sometimes the cause of humanity is better served by also sending a copy to the coroner or district attorney.

No, doctor, neither the coroner, nor any other official or person, except the parents or guardian, has the authority to *compel* intelligent treatment of children in California, even though they may be strangling to death from a growing diphtheritic membrane as certainly as they would suffocate if thrown into a river. Courts in several other of our states have recently convicted meddlers, cultists and *in instances, even parents, of manslaughter,* under conditions not far removed from those you describe. There isn't much chance for such successful enforcement of law in many places in California at the present time.

The columns of CALIFORNIA AND WESTERN MEDICINE, and even those of a few newspapers, are open for the publication of FACTS such as you mention in the unpublished paragraph of your interesting letter. Let us have more questions of such vital importance from good doctors who are troubled in spirit. The editor will welcome additional comment upon the question raised in this letter and editorial, and will use, with or without mentioning names, such matter as appears useful to the cause we all espouse.

Are Modern Public Health Departments Becoming Great Organizations for the Practice of Medicine?—A growing number of writers, medical and non-medical, believe that many health departments are going far beyond their legitimate business. Doctor C. D. Selby, in his inaugural address as president of the Ohio Medical Association (Ohio Med. Jour.), sums the situation up in a state where the issues have been much discussed: "The 'modern health department' wishes to perform all kinds of medical service for the public, vaccinations, Schick tests, the Dick treatment of scarlet fever, the treatment of tuberculosis, etc. It is hardly necessary to say that this policy is fallacious. It is our duty as physicians and as a profession to bring health officers to understand that *every physician is a health officer,* and that these treatments which health officers are attempting to apply en masse are treatments that can much better be applied by individual physicians. The best health officers are those who secure the co-operation of physicians and persuade them to become individual health officers for their clientele."

Dr. O. Pine queries: "Why all this frenzied haste to embalm the 'family physician' before he is dead? Only his purse has been lacerated, not his usefulness!"—Atlantic Medical Journal.

The Month With The Editor

Notes, reflections, extracts from correspondence, comment upon medical and health news in both the scientific and public press, briefs of sorts from here, there and everywhere.

Curing Broken Legs by Prayer—The most audacious attempt of the unqualified to secure *legal* right to practice medicine, of which we are informed, was exemplified during the recent legislative session, when a well-organized attempt was made to allow "treaters by prayer" all the rights and privileges of educated licensed physicians.

Among other things, this proposed law was to grant "any employe' the right to select "treatment by prayer or *spiritual means*" in lieu of medical and surgical treatment.

AND the "prayer" or spiritual "doctors" were to have full and complete authority in the preparation and signing of official documents upon which the consequences of injury, including compensation are based.

There is an interesting and more complete story of this and some other curious and significant measures which were before the last legislature, and what happened to them, and why, in the June issue of *Better Health* magazine. More of the story will be told from time to time.

"Why Patronize Your Family Doctor," asks one of our correspondents, "when our tax-supported public health authorities advertise to render important doctor's services *free* for you—regardless of your wealth—as they do in the following from the State Board of Health Weekly Bulletin: "The Bureau of Child Hygiene of the California State Board of Health is sponsoring conferences in many counties throughout the state, where *pre-school children* may be brought for *free physical examinations.*"

A "BEST SELLER"—A man went into Cohen's Book Store and asked: "Have you a copy of 'Who's Who and What's What,' by Jerome K. Jerome?"

Cohen replied: "No, sir; but we've got 'Who's He and Vot's He Got,' by Bradstreet."

MORE MESSAGES ABOUT THE HISTORICAL NUMBER

ON BEHALF OF THE SAN DIEGO COUNTY MEDICAL SOCIETY, permit me to express our sincere appreciation of and admiration for the splendid Journal which your untiring efforts have evolved and which is now known as California and Western Medicine.

At the recent meeting of the State Society in the Yosemite Valley it was with pleasure that we noted the commendations for the Journal which came from all sides and we feel that California has good reason to be proud of one of the foremost medical publications in the United States.

Very sincerely yours,
George B. Worthington, M. D., President.

"MY DEAR DR. AND TOO INDULGENT CRITIC," writes Doctor Adolph Barkan from Zurich, "may an octogenarian colleague be permitted to thank you for the few beautiful lines, and the sentiment expressed through them, which you have seen fit to put at the head of my sketchy remembrance of Macewen?

When in the year 1869 I came to the Pacific Coast, in fulfillment of my boyhood's determination—to cure the blind and live in California—there appeared the Pacific Medical Journal in S. F., edited by that lovable man, Dr. Henry Gibbons, Sr. Will you put that alongside the historical number of California and Western Medicine? Let us—including myself into the ranks of the generation of medical men still young in spirit—be grateful for the progress achieved in our holy and beautiful profession, and under able leadership ever continue the good work. Again, my dear Dr., I thank you, and wish you well and many years more of progressive and encouraging work."

—THIS IS TO CONGRATULATE YOU AND THE AUTHORS on the very excellent articles which recently appeared on The Historical Number of California and Western Medicine. The articles were splendidly written and edited and made very interesting reading, in addition to being a change to many of us. I hope that in the future you may see fit to publish other similar articles.—J. Park Dougall, M. D., Los Angeles.

—ACCEPT MY CONGRATULATIONS on your interesting historical May number. Some of these pioneer physicians deserve our admiration for their courage and resourcefulness. Without the help of our modern laboratories some very good work was done.—Kaspar Pischel, San Francisco.

Preventing Babies—Doctor Pusey, ex-president of the A. M. A., in an address before the recent birth control conference, pointed out that legitimate practice in this field is a responsibility of physicians. "Doctors' methods," he said, "do not appeal to the mooning sentimentalists, or the so-called moralists, or to the ethical dreamers who would like to have mankind not as it is, but as their dreams would picture it."

—The 821 doctors who attended the convention passed this sensible resolution: "Resolved, That at this session of the Sixth International Neo-Malthusian and Birth Control Conference this meeting of American physicians affirms that birth control, being a very important and complicated problem requiring scientific study and guidance, comes properly within the province of preventive medicine, and that the subject should not only have a place in the programs of county and state societies and of the American Medical Association, but also becomes a part of the work of clinics, hospitals, and other medically supervised organizations engaged in scientific study and prevention of disease and crime."

THE 1926 A. M. A. session will be in Dallas, Texas. Let's begin to plan now and send at least 1000 California, 200 Utah, and 100 Nevada physicians to that convention.

Our New Trustee—Doctor Joseph A. Pettit, Portland, has been elected trustee of the American Medical Association to fill the unexpired term of Doctor W. T. Williamson of blessed memory.

Trusteeship of the American Medical Association for the West Coast section is a particularly important position, and we have every confidence that Doctor Pettit will represent us wisely.

Another Friend Honored—President-Elect Wendell C. Phillips of the American Medical Association is another of those "barefooted farmer boys" who have made good.

He plowed barefoot when he was so small, that the plow-handles would toss him in the air when the plow struck a rock.

—Did the hard work injure or benefit him? He believes the latter.

The Tonsil Crusaders—"Undoubtedly," believes the editor (Jour. Ind. Med. Assn.), "the pendulum has swung too far toward radicalism in the removal of tonsils to cure or relieve many diseases or symptoms of the human body, but this conclusion must be based on the knowledge that the worst offenders are the commercial operators who operate for the fee or the experience; or, on the other hand, by the class of physicians who are enthusiasts or faddists concerning a procedure that, while having its limitations, is considered to be beneficial in a large proportion of cases."

"When all is said and done, the point made by Barnes may be emphasized, and that is that the tonsils should never be removed without adequate cause, but when such cause exists the loss of a questionable functioning power should not be used as an argument against their complete extirpation."

—Certain clinics, health centers and groups of California health uplifters are still beating the bushes for children whose tonsils they want out on the say-so of technicians. *It takes as good a doctor to tell when a tonsil should come out as it does to take it out.*

Blood Money—Now that the Supreme Court of the United States has ruled that the Harrison Narcotic Law *is purely a revenue measure,* we find our country in an unenviable position, morally and socially speaking, in another of its tax practices.

Heretofore it has generally been denied by government officers that the law was primarily a revenue measure.

—It would look better to keep on being untruthful about it.

Balto!—The self-designated "Citizens' Medical Reference Bureau" is making itself again ridiculous in objecting to the proposed statue to the dog Balto because of his glorious run to Nome with life-saving antitoxin. *These people seem to think that Balto was a family doctor.*

Exercise, Work, Play—Queen Victoria never walked when she could ride, and exercise in general she avoided. She lived to a ripe old age. Walter Camp, who all his

life had kept himself in the "pink of condition," died much younger of cardio-vascular troubles. "What is one person's poison is another's food," is quite as true today as it was before we all became "educated."

Testimonial-Giving Again Becoming "Stylish"—When Chambers of Commerce made "leg shows" "stylish" and "theoretically respectable," they opened quite a "jack pot": they put a punch into the craving for publicity.

—Vanity looking about for its essential flattery discovered that the old custom of getting our names before the public by giving testimonials had been allowed to drift into obscurity, if not unrespectability.

—So, by reviving the custom and making it respectable by engaging the help of a few respectable people of prominence, a chance is provided to satisfy the publicity craving for another large group.

DR. STABEL MAKES THE STATEMENT (*Better Health,* June) that the successful country doctor requires more knowledge, experience and devotion than his city colleague. "The latter," says the doctor, "has specialists at his command to *divide* the responsibility which the country doctor has mostly to bear alone."

THE study of scientific medicine and the practice of it is a religion; it is a good deal nearer a religion than any other vocation on this earth. It ought to be kept far above the suspicion or the taint of commercialism.—Hubert Work.

Osteopaths "Educate" the Public—Some of the things said at the recent state convention of osteopaths that the newspaper men attached value to were:

"Professor Emery, widely known cancer expert," is credited with the startling statement that "The same influences that cause painful flat-foot, falling down of any of the organs, teeth-decay, and other breaking down of tissues, are the influences that cause cancer."

The old chestnut that cancer "is a disease of civilization" was polished up by Emery, who said: "It is not known among primitive people, nor was it known among the ancients—all of whom have the most perfect teeth, as I found in examining the skulls of the Egyptian mummies, those of the Peruvian Incas, those found in the catacombs at Rome, and in my world travels among primitive people."

There is plenty more of the same sort of misinformation about other subjects that some people no doubt will accept and act upon.

Oh Those Hollow Hairs!—"Progress of medical science, as developed by a New York barber and advertised by a sign in his shop, according to the American Mercury:

"'After the hair is cut it should be singed in order to close up the ends. This prevents your catching cold in the head through the open ends of the hairs.'"

BOOTH TARKINGTON (American Magazine) makes the doctor say: "Why shouldn't we eat, drink and be merry, since tomorrow we die?" Well, the easiest answer is another question: But suppose you don't die? And the confirmation the world is seeking is confirmation of the ancient but shaken faith in that supposition. Man wants to know if there is eternal life and if there is God. If he finds an affirmative answer to either question, he'll accept it as the answer to both. If he finds that death is merely a change in continuous life, he'll know there is God. Isn't it curious that in the beginning man knew perfectly well that death was only a change in life, and not extinction of himself at all?"

There is much more in the essay by this delightful author that may be read with interest and profit.

It Is Said to Cure "Fear Complexes"—Mr. Samuel F. Rutter, Federal Prohibition Director, reports that Northern California residents legitimately consumed 1,200,000 pints of liquor in the twelve months ending May 1.

This represents the amount of spirits prescribed by physicians. There are 7300 physicians in California who have the right to prescribe liquor, but proceedings are under way to revoke the licenses of forty-five of these.

California State Hospitals Establish Beauty Parlors for Patients—According to a recent news item from Sacramento, Mr. Walter D. Wagner, Director of State Government Hospitals, has established beauty parlors in state hospitals for their "wonderful psychological influence on the women inmates."

"The Tragedy of the Dirty Room"—Why tragedy instead of tragedies we don't know, but in any event THE tragedy is, that dirty rooms cause asthma, according to an amazing interview displayed in the press as being from one of our California doctors.

Your back aches because:

"Kidneys," said the herb man.
"Prostate," said the G. U. doctor.
"Flat-foot," said the shoe doctor.
"Pelvic trouble," said the gynecologist.
"Infected teeth," said the dentist.
"Mal-adjustment," said the osteopath.
"Impinged nerves," assured the chiropractor.
"It don't ache," emphasized the Christian Scientist.—Medical Herald.

"FATE makes no free gifts; it sells, for a price. The price is heavy. Machine guns, cancer, slums, the penny newspaper—these are a few items of the tribute we pay to fate for the privilege of not being savages."—Aldous Huxley (Vanity Fair).

Our Sins Will Find Us Out—"The responsibility of diagnosing a healthy heart," says the Medical Standard, editorially, "should not be shirked because of the professional risk which the physician runs of giving a good prognosis in errors. . . . An attitude of playing for safety would be more justifiable if heart cases were doomed to end with the dramatic abruptness usually depicted by the novelist and imagined by the laity. . . .

"The tendency to excessive diagnosis of heart disease was rife during the war when thousands of men were rejected as unfit for service, or were invalided out of the army, on the slenderest evidence of valvular disease and a mistaken notion of the ambit of cardiac manifestations. The morale of many ex-service men has been damaged to such an extent by this wrong diagnosis of heart disease that they will never again consider themselves fit for work. . . .

"Whatever the temptation to do otherwise, there is seldom any justification in the realm of heart trouble for other than a preliminary statement that either there is something wrong with the heart or there is not."

It takes a good doctor and an honest one to affirm that there is nothing important the matter with a given person's heart. It is much easier and safer for the unskilled to express a "strong suspicion," which is all the average patient needs to develop a first-class "fear complex." This most popular "fear complex" is surely being stimulated at present and, what is even worse, is being capitalized by people who are not adequately prepared in intelligence or experience to tell the difference between an emotional tachycardia and an arhythmia. Ignorance, playing "safe," or cupidity explains an unknown amount of the "heart disease" statistics now so spectacularly featured.

An Unusually Intelligent Instrument:

"Dr. ——, chiropractor, has equipped in his office a new nerve pressure register, which will register every degree of inflammation anywhere in the human body."

This is a copy of an advertisement clipped from a California newspaper and sent in by one of our members. We admit our inability to offer comment that would be understood by anyone who would fall for such bunk. We are informed that this chiropractor apparently is prospering, and in a community where at least the average amount of "health education" is passed around.

A Gruesome But Effective Health Measure—Scaring people into vaccination against smallpox by placing the sick, victims of this repulsive disease, near windows so that passersby may see them, is reported as proving an effective health measure in one place in New York. The health officer who introduced the innovation to help him overcome opposition to vaccination says: "During thirty-five years of continuous service as health officer here, I have never seen so marvelous a change in public sentiment on any such matter as occurred in the town referred to. Vaccination became, during the following week, a

popular pastime, and there are very few in this locality now who have not been vaccinated, although this happened twelve years ago."

THE docs do wrong when they protest against prohibition. No man should condemn an institution without first giving it a test.—Bugs Bear.

"Fake Prescription Forms"—So many counterfeit doctors' prescriptions for liquor are in circulation that the Internal Revenue Department has been obliged to issue an entirely new form, more difficult to duplicate.—American Registered Pharmacist's Journal.

"WHAT a man does when he has nothing to do shows what he is."

Doctors are Citizens First—They are morally obligated to interest themselves in civic affairs and should be as active in promoting mental, moral and spiritual welfare as they are in promoting physical welfare.

"Short Turn Ahead"—That concern which is circularizing doctors and offering—for a price—to prepare and release articles to the public press under the doctor's name is finding some doctors who prefer notoriety to fame.

Who Said Fame!—Doctor W. E. Balsinger who, according to some newspapers, "gained international fame by transplanting one of Jack Dempsey's ears to where his nose should have been," was in San Francisco recently. He wanted an apology from Dr. George Warren Pierce, who has been quoted as saying that new noses built of paraffine won't last.

Does this confirm the old saying "that a prophet is not, etc."?

PROGRESSIVE INDUSTRIAL PHYSICIANS will find much to ponder over in Report No. 29, Industrial Fatigue Research Board of Great Britain.

The High Cost of Babies—Ida L. Allbright (Century) supplies food for thought in this well-told story of a "layman who acknowledges a large debt of affection and thankfulness to many men of the medical profession." Mrs. Allbright had her experiences with family doctors, specialists, groups, and clinics. Read her story, doctor; it may help you with your problems.

California Leads in Smallpox—Also in anti-vaccination propaganda. The two things go together. We led all the states during 1924 with 9425 cases of smallpox and fifty-six deaths. Ohio was our closest competitor, with 5597 cases and fifty-eight deaths.

Oh well, the anti's must spend some of their money, but why purchase a repulsive disease like smallpox with it? The pathetic feature of this *totally* (100 per cent) useless and unnecessary injury to health and sacrifice of life is, that many of the victims were children.

Deleting Babies—Extensive publication of the decreasing birth rate is now pointed to by some to prove how much more effective the modern birth control clinic is than was the old-fashioned doctor.

Mr. Ross, California's vital statistician, is quoted in the press as stating that: "Figures show that whether contraceptive methods are taught in clinics or not, their practice is general."

Mr. Ross also claims that: "The California average family of 2.68 persons is smaller than in any of the twenty-seven states that are in the registration area."

—Don't forget, Mr. Ross, that California must lead in "birth control," as well as in berries or anything else she attempts to do—or should I say not do.

Smith, being introduced to golf for the first time, had hit the ball a terrific whack, and sent it half a mile.

"Now, where do I run to?" he cried excitedly.

Are the Violet-Rays a "Nearly Cure-All"?—After reading that most remarkable, heavily headlined and illustrated interview with an M. D. from a Class A San Francisco Medical School the other day, we felt an inclination to turn over to the advertising "herbalists," "mental healers," and what not for some quiet reading.

Doctor, several of us are "over 40," our blood pressures are higher than they should be, but we do hope you are wrong, at least, in your alleged statement that violet-rays "stimulate the growth of cells in the lining of the blood vessels."

When Is a Hospital Not a Hospital?—According to William C. Hassler, M. D., the official public health doctor of San Francisco, "*Christian Science Rest Homes*" are hospitals—at least from legal and public health viewpoints. The doctor elaborated his statement to say: "Unquestionably, this institution is a Christian Science hospital, but Christian Science does not recognize disease and so does not recognize hospitals as such and calls them rest homes."

—Nay, nay, holds Mr. McLeod of the Christian Science Publicity Department: "The statement that 'Christian Science does not recognize disease' is a complete misapprehension of its teaching and practice. In a relative sense, Christian Science recognizes disease as a mortal condition, to be rejected and destroyed *in accordance with God's law in the same manner as Jesus Christ destroyed it.*"

—This and other similarly significant statements from similar sources makes illuminating reading, particularly in connection with proposals to change the title of Christian Science practitioners to Doctors of Christian Science and with active attempts to give these people, BY LEGISLATION, all rights to treat patients under the Industrial Accident Law now included in physicians' licenses.

"That 'grand old man,' Dr. David Starr Jordan, has in no degree lost his sense of humor. His talk on 'Sciosophy' or the science of ignorance, was a scream."—San Diego County Medical Society Bulletin.

Why Some Leave Home:

"The city visitor was consulting the oldest inhabitant. 'How many people in this town now?' he asked.

'Twenty-five, sir.'

'How many did you have last year?'

'Twenty-five, sir.'

'That's strange, aren't there any babies ever born in this town?'

'Yes, sir. But most every time a baby is born, *somebody* leaves town.'"

Birth controllers, take notice!

Catching Them Young—"Clinics for children of preschool age which have previously been held at different homes will now be held in the association room *under the direction of the trained nurse and two assistants.*"

This quotation from an official tax-paid-for publication is representative of a type of quite familiar literature.

—A recent definition of a clinic is that it is a place where everyone but doctors practice medicine.

Playing Both Ends Against the Middle—According to a recent California Superior Court decision, chiropractors may now demand examination and license as drugless healers (if they pass) of the Board of Medical Examiners. Dr. Pinkham predicts that "there will be a rush of chiropractors to qualify under this ruling and he foresees great confusion arising from the dual jurisdiction. If a chiropractor holding licenses from both boards violates a medical regulation and has his license revoked by one, he can still operate under his license from the other."

—This dual convenience will provide many other kinds of *opportunities.* However, the outstanding fact is that even a drugless license from a board of educated physicians is more valuable to a chiropractor or other "doctor by law" than is the most attractive certificate that his own board can invent.

Another Fad Passing—Dr Matthias Nicoll, health commissioner of New York, has issued a warning against self-dosing with iodin. He points out that while this chemical may prevent goiter in children, it may also do harm to adults who have goiter already developed.

From numerous other reliable sources belated warnings are being issued against the indiscriminate use of iodin as a goiter preventive.

Iodin is a chemical and by no means a harmless one. Like other medicines, it should be prescribed by an educated physician when and where indicated, either for curative or disease preventive purposes.

—CALIFORNIA AND WESTERN MEDICINE has been preaching caution since the "iodin fad" first had its remarkable flare-up.

Medical Economics and Public Health

Both Timely and Important—The House of Delegates of the A. M. A. passed the following resolution at the seventy-sixth session:

"RESOLVED, That it is the sense of this House of Delegates that periodic health examinations should be conducted by medical men and neither dominated by nor controlled by lay organizations, for the reason that the relation between the patient and the physician is an individual matter, and anything that disturbs such relationship is detrimental to the best interests of the patient; and be it further

"RESOLVED, That it is the sense of this House of Delegates that every Fellow and member of the American Medical Association should live up to the spirit and letter of this resolution."

Health Officers Recently Appointed—According to the official bulletin of the California Board of Health, W. J. Quinn, M. D., of Eureka has been appointed health officer of Humboldt County to succeed F. R. Horel, M. D., of Arcata, who has held the office for many years. Doctor Quinn is licensed to practice medicine and surgery in California, and is a member of the California Medical Association.

J. W. Truxaw, M. D., has been appointed health officer of Anaheim, Orange County, to succeed George A. Paige, M. D. Doctor Truxaw is also a member of the California Medical Association.

Gilbert S. Vovard, M. D., has been appointed health officer of Sierra Madre, Los Angeles County, to succeed E. L. Jackson, M. D. Doctor Bovard is a member of the California Medical Association.

J. W. Camp, M. D., has received the appointment of health officer of La Habra, Orange County. Doctor Camp is a member of the California Medical Association.

Mr. M. B. Eaton has been appointed health officer of Sunnyvale, Santa Clara County, to succeed Mr. M. J. McGinnis. Mr. Eaton is not licensed to practice medicine and surgery in California, and is not a member of the California Medical Association.

The Physician and Narcotics—"The United States Supreme Court has just recently handed down an important decision dealing with the Harrison anti-narcotic law," says the Santa Cruz Sentinel, editorially. "The court holds," continues this editor, "that the law is strictly a revenue measure and must be so construed, interpreted and applied."

It also disposes of the more vexing problem, which has often been raised under that law, whether or not a physician may legally give small doses of morphine or cocaine to an addict under treatment.

"Dealing with this question, the court says: 'That a physician who in good faith dispenses small quantities of morphine or cocaine to an addict for the relief of conditions incidental to such addiction commits no offense within the Harrison anti-narcotic law.'

"Further on it says: 'The treatment of drug addicts and the wisdom or propriety of such treatment not being a matter for the determinates of Congress through the medium of a revenue measure.'

"The case upon which this decision was based was taken to the highest court of the land to test the powers of a physician under the law. That the court imposes the utmost trust in physicians in handling the dangerous drugs is shown by the fact that the decision does not even caution the physicians to exercise care, believing that under their oath when entering the profession they will do all in their power to aid an addict and will use wisdom and discretion in administering the treatment."

Another Health-Prolonging Group—A number of our members have sent in to us a most interesting document and return postcard on the stationery of a new "stay well," "positive health," "longer living," "college," "institute" association, or something of the sort. The idea of this new crowd is very much like the ideas of those that are now, and those more numerous ones that have been, as well as some that are now and that won't be in the future. Their whole philosophy seems to be that because someone said (untruthfully) that the Chinese pay their doctors when they are well and require their services without pay when they are ill, the idea should be applied in America.

It probably would not be an exaggeration to state that the organizations that have attempted this and failed—at least for everyone except those who handled the money—would run into the hundreds.

The letter from this new organization which seems to have upset so many of our members shows on its face that it is prepared by people who have almost no fundamental conception of the problem they are undertaking. They fail to appreciate the difficulties that great governments have had in trying to apply this idealistic principle to everyday life. We anticipate that this latest of the many of these that are reported to us every year will not grow to sufficient magnitude to require any serious investigation and study by our departments that deal with problems of this character.

" 'Modern medicine,' believes Doctor Sir David Bruce, 'must change its strategy in the battle against disease. It must begin the offensive and not await the attack.' "

Five Fundamental Standards for Ambulatory Patient Services—1. The outpatient and the bed services should be regarded as intimately associated phases of hospital work and should be unified as fully as possible as to medical staff and as to administrative organization.

2. The number of patients accepted for care should be limited and regulated according to the facilities of staff, space, and equipment.

3. Adequate records should be maintained of the medical work, the attendance, and the income and expenditure. All the medical records of a patient should be filed together.

4. Adequate laboratory service should be made available for the outpatient department.

5. Nursing service, social service and clerical service should be provided. Physicians should be able to devote their time to their patients and be freed from mechanical and clerical duties.—A. M. A. Bulletin.

Effective Sociology—"Are the passing of the old-fashioned hickory stick and the modern criminal wave related?" asks the Medical Standard, editorially. "So-called old-fashioned folks," cautions the editor, "think so, and take issue with the modern professors of psychology and sociology. Yet there is one modern professor who professes the beliefs of our fathers. To quote Dr. Rudolph M. Binder, of the sociology department of New York University, 'Spank 'em in moderation. Spanking is a nature physical cure for the tense nervous cause and reaction of misbehavior.' Which licenses dad to say, 'Accompany me to the wood-shed, Ernest, and we will review our lesson in sociology.' "

Babies Come High—"Day nurseries, convalescent homes, and fresh-air homes in New York City represent an estimated investment of over $15,000,000," states the annual report of Association of Day Nurseries.

"The budget of the Bureau of Child Hygiene of the New York City Department of Health," continues the report, "amounts to about $900,000 for salaries alone. A study made of the day nurseries shows that this particular type of agency is reaching not more than 9000 families in a year, and takes care of about 15,000 children as a maximum. The total cost of maintaining the day nurseries is about $1,000,000 a year."

Making Charity a Business Trust—"And, really," says Harper's Magazine, "an overdevelopment of that great industry of raising money by drives and campaigns and organizations for purposes which the organizers and the drivers believe to be good may come—if it runs to excess—to be open to the same objection which concerns the diffusion of the funds of the taxpayers. It may take away from the givers whom it reaches the ability to give their own funds to objects they think about and care about. When these great ebullitions of money-raising go out of style, that will be one of the reasons for it. People will say: 'We would rather ourselves give to what we wish to help than give to you to give to what you wish to help.' That is where the drives are weak."

California Medical Association

THE YOSEMITE SESSION

The fifty-fourth meeting of the California Medical Association held at Yosemite Valley was a success from the viewpoint of the program presented and from that of the attraction of the meeting place. The total registration was 839, almost twice that in 1922. Few hotels bring the membership closer together fraternally than does the Yosemite Lodge, where only members of the California Medical Association and their families gather during the annual meeting.

Oakland, the home of our president, Edward N. Ewer, has been chosen as the place of meeting for the 1926 session.

Data about the annual meeting in Yosemite held on May 18 to 21, inclusive, could not be published in the June issue, as CALIFORNIA AND WESTERN MEDICINE went to press on May 20, prior to the close of the annual session. In this issue, therefore, are published the speeches of the president, president-elect, a full account of the Bunnell Memorial exercises, and the transactions of the House of Delegates. Because of the volume of material submitted, it is deemed wise to hold the minutes of the Council for the August issue. Certain Council action, however, should be brought to the attention of the membership early.

Clinical Prizes—As published in the December issue of this Journal, three prizes were established by the Council in November, 1924, in the sums of $100, $75, and $50. After further consideration, it was felt by the Council that the amounts were too small and, therefore, at its last meeting the Council rescinded its former action and established two prizes for $150 each—one for a paper on original research, and one for a paper on a clinical subject, to be competed for by members of the California Medical Association only. The competition will be so arranged that announcement of the prize winners can be made at the 1926 annual session to be held in Oakland. As soon as the committee has been appointed and the rules and regulations governing the competition formulated, full publicity will be given through the columns of CALIFORNIA AND WESTERN MEDICINE.

Preservation of the History of the California Medical Association—For some time the Council has felt that it is desirable to have a permanent committee to compile and keep up to date a full history of the organization, membership, and transactions of the California Medical Association, as the files and records prior to 1907 are very incomplete. At the Yosemite session the chairman of the Council was authorized to appoint such a committee. This is a most important function of the Association and it is hoped that any members who have information on the subject will volunteer to collaborate with this committee.

Ownership of X-ray Plates—As many inquiries are constantly being received at the state office from doctors and hospitals, the general counsel was instructed by the executive committee to submit a form that would prevent question arising in either the minds of the patient or the doctor, hospital, or laboratory as to the exact status of x-ray plates. In compliance therewith the general counsel submitted a memorandum which was adopted in principle by the Council with the recommendation that it be formulated definitely for publication to the membership.

Certification and Recognition of Delegates at Annual Sessions—Much confusion and debate has always arisen at the annual sessions of the House of Delegates owing to the lack of definite rulings and regulations regarding the certification and recognition of delegates and their alternates. After much deliberation and consideration the Council has referred the matter to the executive committee with the recommendation that the proper amendments to the Constitution and By-Laws be prepared for consideration at the 1926 annual session, and that such amendments be made in accordance with the rules and regulations of the A. M. A. This means that only those delegates and alternates who are duly elected and officially certified to by their county society at least seven days prior to an annual session will be entitled to a seat in the House of Delegates.

Because of the non-attendance of so many delegates, the Council feels that "no delegate absent without notification to his county secretary or the state office should be considered eligible for representation the following year," and will recommend that this question be considered by the House of Delegates at its 1926 session, and that action be taken by that body along the lines quoted above.

DEDICATION OF MEMORIAL PLAQUE TO LAFAYETTE HOUGHTON BUNNELL, M.D.

Exercises held by the California Medical Association near Bridal Veil Meadow, Yosemite Valley, California, Tuesday, May 19, 1925, at 10:30 a. m.

The day was perfect. A gay company had assembled and formed themselves into a semi-circle, sitting on the greensward in a charming glade on the bank of the Merced opening into Bridal Veil Meadow.

The ceremony opened with what might have been a formal military salute, so well timed were the reports of a series of blasts from the road work near by.

Emmet Rixford, M. D., of San Francisco presided.

DOCTOR RIXFORD—I wish to call your attention to the completeness of arrangements made by Mr. Lewis, Superintendent of the Park, though he seems as surprised as any of us at this opening of the exercises with a military salute, as it were. One might almost imagine an aeroplane dropping bombs in the Valley to heighten the contrast of conditions of today with the mode of operations employed against the Yosemite Indians in 1851.

We are gathered here in this spot of wondrous beauty, with El Capitan towering aloft across the Valley and Yosemite Falls visible in the distance, to dedicate a tablet to the honor and memory of Doctor Lafayette Houghton Bunnell. I will tell you more about him later.

This site was chosen after much debate and many miles of running, and I know that all present will agree that it is not only a most beautiful spot, but is also most appropriate for a monument to Dr. Bunnell. Three sites were

Bunnell Memorial Exercises, Yosemite, May 19, 1925

considered—a spot near the foot of El Capitan, whose grandeur is a major theme in Doctor Bunnell's book; a second near the Royal Arches and Indian Cave, where several of the incidents of the stay in the Valley of the Mariposa Battalion took place and which had the advantage of being more accessible to the public; and third, this secluded, but lovely spot.

Bunnell was not *the* discoverer of the Valley, but merely a member of the Mariposa Battalion, a company of thirty or forty, the first white men to enter it. His real distinction

lies in the fact that he suggested the name Yosemite Valley, and this little knoll leading out to the river beside the Bridal Veil Meadow is, as nearly as can be determined, the exact site of the first camp in the Valley of the Mariposa Battalion, and it was here that the name was suggested by Doctor Bunnell and adopted.

There is much that is indefinite in Doctor Bunnell's book, but the statements are clear that the first camp of the battalion was near the foot of the trail beside a meadow where the horses were staked out to graze. The company had Indian guides familiar with the best camping places, and we know that this very spot was an old Indian camp site because of the six or seven holes in the flat rock yonder where the Indian women ground their acorns. The identification was made by Mr. Lewis after carefully studying Bunnell's description with reference to the local topography.

Now for a brief history of the plaque. A committee was appointed two years ago, on the suggestion of Doctor Howard A. Kelly of Baltimore, that the medical profession erect a suitable memorial to this pioneer physician. The design by Mr. Paul J. Fair of the National Forest Service is of a grizzly bear representing the spirit of the Valley, standing erect in surprise and perhaps mixed emotions, viewing the entrance into his domain of the Caduceus, emblematic of the medical profession. Mr. Fair modeled the plaque with suitable inscription in honor of Doctor Bunnell, and Mr. Fred Storey cast the plaque in bronze.

The design was approved by Mr. Stephen T. Mather, Director of the National Park Service, after it had been passed upon by Mr. Daniel R. Hull of Los Angeles, landscape architect, and permission was given for the California Medical Association to place such a memorial plaque on some boulder at a suitable site in the Valley.

The plaque is to be mounted in permanent fashion on the flat side of the great boulder next the river, six feet or so above the ground.

The president of the California Medical Association, Doctor Granville MacGowan of Los Angeles, will now make formal dedication of the plaque.

DR. MACGOWAN — Fellow-members of the California Medical Association: As a learned society we are gathered together here in this, one of earth's most impressive spots, which had it been within the ken of the ancient Greeks would well, instead of Olympus, have been chosen as the home of the gods. Here are, within the reach of the senses, all of the attributes of nature, which cultured man without the belief of a sole sublime ruler might well with reason worship. The echoes of the voices of the waters and winds continuously surround us; soothe the traveler and lull him into oblivion; the wondrous groves spread mystery; the towering cliffs of ice-ground granite portray the hidden powers of might and strength; the lush meadows carpeted with delicate and tender flowers springing out from the concealment of the rich growing grasses reveal the protecting and sustaining powers of our mother earth. And all this majesty which we so admire and view with reverence had been, until a little less than three-quarters of a century ago, entirely concealed from the knowledge of the men who for thousands of years alternately created and destroyed civilizations growing out of the mental needs and ambitions of the white race.

Until 1851 no pale face had set foot upon the Valley floor. It had for all this time, within the memory of aboriginal man, been the abiding place and inheritance of a tribe mean of spirit and base of blood which was the scourge of the neighboring Indians and the terror of the haciendas of the plains. They absorbed no Godlike spirit from their environment. So secure felt they in their mountain fastness that when the work of the white men seeking for gold along the Valley of the Merced, the traces of whose activities may yet be seen, approached too close to the Valley gates, their dissembling chief, old Teneiya, picketed their work like a modern walking delegate and drove off the laboring force of Mission Indians who feared the Grizzlies, raided the stock, and refused parley with the commissioners of the government of the United States and defiantly brought about a state of war. It was then that the volunteer battalion formed in and about Mariposa, commanded by Major Savage, an Indian trader and commissioned by the then Governor of California—MacDougal—was authorized and instructed to pursue these Indians and bring them into camp. One of these volunteers was a young man of 29, Lafayette Houghton Bunnell, the son of a Detroit doctor, who had received a partial medical education and had served at the beginning of the Mexican War as a hospital steward and later as a doctor. Young Bunnell was in the great adventure in California to seek his fortune in the gold mines. He attached himself to the military expedition through worship of the grandeur of mountain scenery, and a laudable curiosity to become further acquainted with the immense cliff, El Capitan, that he had seen from the old Bear Valley trail on the Merced River, looming in the Sierras.

A time of storm and heavy snow was chosen by the astute commander to approach the Valley through the totally unknown byway of the Mariposa trail. The surprise to the Indians was complete, and the expedition entirely successful. That night at the campfire, Bunnell, who was a devout nature lover and believer in America and American things and of a lyric spirit, proposed to those volunteer soldiers to name the Valley and presented to them the old Indian name by which the outlaw tribe was known to their neighbors surrounding them—The Grizzlies, Yosemites, the Terrible Bandits, of whom all were in fear. He wanted a true local name for the wondrous geographical basin that they had discovered. It received its baptism by the unanimous viva voce vote of the conquerors.

Bunnell did not remain in California nor did he practice medicine here, but returned to his old home in La Crosse, Wisconsin, where he enlisted in the United States Army, and was appointed a hospital steward and served during the entire Civil War, being promoted to assistant surgeon, and when he mustered out in July, 1865, had a commission as a surgeon, having in the meantime obtained a diploma in 1864 from an ephemeral institution in his own town—the La Crosse Medical College; his matriculation and class courses in the School of Hard Knocks and Internship in Camp Necessity justified the degree.

Later in life (he died in 1903) he wrote a most interesting book upon "The Discovery of Yosemite and the Indian War of 1851," which I would recommend now for any of you who are interested in tales of Indian warfare to read, because it is wonderfully descriptive of the early days of California and portrays the character of the man.

The California Medical Association has desired to keep alive the memory of this gentle, inconspicuous but honorable brother, and for this purpose we are here in the heart of the great Sierras dedicating this plaque, commemorating Doctor Lafayette Houghton Bunnell.

As appropriate I ask you all to rise, raise your left hands, repeating after me the 11 o'clock toast of a great benevolent organization to which many of us belong and which bears the name of the noblest of the denizens of this valley at the time it was discovered, "Cervus Alsus," To our absent brother.

DOCTOR RIXFORD—Mr. W. B. Lewis, Superintendent of Yosemite National Park, has given the committee the fullest co-operation and invaluable assistance. Aside from his official position, Mr. Lewis has always taken great personal interest in Yosemite Valley, and is a friend and often a friend in need of those who would enjoy the scenery of this world's most beautiful valley. Mr. Lewis will speak as representative of the National Park Service.

MR. LEWIS—Ladies and Gentlemen: I saw my name on the program for an address. Please do not look for one; it is not my business. I would like, however, to make an observation or two, and extend to you a hearty greeting from the National Park Service and Yosemite National Park, and also to extend to the California Medical Association the appreciation of the Park Service for doing this thing.

I think it is great to perpetuate things of historical interest. The old-timers are fast passing away, and each day we lose something of the early history of the Valley. It is only now that we are picking up threads and marking old sites. I think it is a wonderful thing to mark this place as the first camp of the white race in the Valley.

In thinking of that expedition of the Mariposa Battalion into the Valley, one cannot but compare conditions with

those of the present. I was thinking yesterday, with the roads in bad condition as a result of recent storms, that many of you on your way to the Valley felt you were undergoing severe hardships and probably criticized the Government for not having spent more money on the roads and Mr. Ford for not having put in better upholstery, and couldn't but wonder what Bunnell and his party had to criticize for the conditions then found.

Out of a camp of forty or fifty men it seems only Bunnell had an appreciation of the Valley and its grandeur. The rest were more occupied with hard service and work, and the idea of pursuing and catching the Indian. Bunnell was the only one who took time to show appreciation for wonders of the Valley and to make notes, and in later years to write a very good book of the expedition.

I do not know if Dr. Bunnell was a surgeon or not, but I am inclined to believe he was. Surgeons get great enjoyment out of exploring around incisions, and Yosemite Valley might well be thought of as an incision in the body of Mother Earth, hence, it would seem that only a surgeon would get the enjoyment out of exploring its depths as did Bunnell.

As a result of his interest in and study of Yosemite Valley during the limited time he was here, the wonders of the Valley became known to the world, but it is doubtful if he even imagined that in the relatively short time that has elapsed since that time, it would come to be known as one of the major scenic attractions of the world visited annually by thousands of people from our own and every other country of the world.

The route of the Mariposa Battalion into and through the Valley can be quite clearly defined. Coming from what is now Wawona on the south fork of the Merced River, they entered the Valley by the old Indian trail leading down from Old Inspiration Point, arriving in the Valley and camping on this site on the night of March 21, 1851. The following morning they crossed the river just below here, at what is known now as Valley View, and ascended the north side of the Valley for some distance, probably as far as Indian Creek, where the party split and scouting parties were sent out, one going up as far as Mirror Lake, one to the top of Vernal Falls, and back down the south side of the Valley to the Cathedral Rocks. By prearrangement they met again near the mouth of Indian Canyon in the evening, and camped there for the night. The following day they returned to Wawona by the same route followed on their incoming march. When it is remembered that all this was done in three days in the month of March, when the entire country they covered was well blanketed with snow, we must not fail to give that group of mountaineers the credit due them. Only the hardiest of men, thoroughly inspired with a sense of duty, would undertake and complete in that limited time such a hazardous journey.

It is, therefore, right and proper that this site be of record, not only in appreciation of Bunnell, but as the most important historical spot in the Valley.

Again let me extend the greetings of the Park Service and its full appreciation of the efforts of the California Medical Association in establishing this memorial in honor of the discoverer of Yosemite Valley.

DOCTOR RIXFORD: It seemed to the committee that it would be most appropriate on this occasion to have set forth something of the history of early exploration in the Yosemite region and the origin of the name. None is so well versed in this matter as Mr. Francis P. Farquhar of San Francisco, who has gathered together a great mass of material on the history of man's coming into the Sierra. Mr. Farquhar will speak as a representative of the Sierra Club.

MR. FARQUHAR — Members of the Medical Profession and Friends of Yosemite: Doctor Rixford has asked me to give you something of the historical background in order to bring out more vividly the significance of the expedition of 1851, when Bunnell came to Yosemite Valley as a member of the first party of white men to set foot here.

It may seem strange that this remarkable spot was so long unknown, but it should be remembered that scenery was not a prime objective among the early visitors to California. Mountains were a barrier and not an attraction. The Spanish occupation was confined to the coast for many years, and, excepting for attempts to reach the coast from the settlements in Mexico by way of the lower Colorado River, little was known of the interior of California. In 1776 Father Garces entered the San Joaquin Valley and visited many Indian rancherias along the river. He did not ascend into the mountains, however, although his visit did fix the name of Sierra Nevada upon its present location. Formerly it had been rather vaguely assigned to the mountains along the coast. Early in the nineteenth century other visits to the San Joaquin Valley were made both by soldiers and priests, but without increasing the knowledge of the Sierra.

It was not until the coming of the American and British trappers that a real interest in the interior became manifest. In the winter of 1826-27 Jedediah S. Smith, one of the greatest of American fur traders, entered California from Utah and crossed the Tehachapi into the San Joaquin Valley. In May, 1827, he crossed the Sierra Nevada and returned to Great Salt Lake. He was undoubtedly the first white man to cross the Sierra, but it is reasonably certain that he did not see Yosemite.

In 1833, Joseph Reddeford Walker left the Bonneville expedition in the Rocky Mountains and came West from Great Salt Lake to explore for new beaver streams. With a large party, he came down the Humboldt River (then known as Marys or Ogdens River), and crossed the Sierra by a route that brought him along the plateau between the Tuolumne and Merced Rivers. A young man named Zenas Leonard, who was clerk of the expedition, published his journal in 1839 in Clearfield, Pennsylvania; and in that publication occur the following words, which constitute unquestionably the first printed description of Yosemite Valley:

"We traveled a few miles every day, still on the top of the mountain, and our course continually obstructed with snow hills and rocks. Here we began to encounter in our path many small streams which would shoot out from under these high snow-banks, and after running a short distance in deep chasms, which they have through ages cut in the rocks, precipitate themselves from one lofty precipice to another, until they are exhausted in rain below. Some of these precipices appeared to us to be more than a mile high. Some of the men thought that if we could succeed in descending one of these precipices to the bottom, we might thus work our way into the valley below, but on making several attempts we found it utterly impossible for a man to descend, to say nothing of our horses. We were then obliged to keep along the top of the dividing ridge between two of these chasms which seemed to lead pretty near in the direction we were going—which was west—in passing over the mountain, supposing it to run north and south."

Following this expedition of Walker in 1833, no record appears of any white men visiting the upper Merced until the mining excitement, although many parties crossed the Sierra to the north and a few penetrated the range farther south. Even the Forty-niners found no attraction in the granite walls of the canyon, guessing correctly that no gold lay therein. Their activities were in the lower courses of the river and in the tributaries on either side. In this lower part of the Sierra, just above the foothills, they came in contact with the mountain Indians, and of the resultant raids and punitive expeditions you have already been told.

The story of the Mariposa Battalion and the expedition that led to the real discovery of Yosemite is best known through the book published many years later by Lafayette H. Bunnell. There are a few other sources of information, however, and these corroborate Bunnell in almost all essential particulars. Dr. Ralph S. Kuykendall has written a very interesting monograph on this subject, based on contemporary accounts supplemented by Bunnell and by other records. It has been reprinted by the National Park Service as a small pamphlet, and appears in substantially the same form in "The Handbook of Yosemite," edited by Ansel F. Hall.

To Bunnell belongs the honor of naming the Yosemite Valley. He wisely selected an Indian name and proposed it to his fellows of the battalion, who adopted it. A few years later James M. Hutchings questioned the spelling and endeavored to substitute "Yo Hamite." It is given in this form on the first pictorial representation of a Yosemite scene ever published, a lithograph of the falls in 1855. Hutchings maintained that his form was the true sound of the Indian name for grizzly bear. Bunnell's

form had the priority, however, and soon became indelibly written in the annals of the Valley. Later studies by Dr. C. Hart Merriam throw light upon the question, showing that the word for grizzly bear among the tribe that actually inhabited the Valley was more nearly as Hutchings gave it, being *Oo-hoó-ma-te* or *O-ham-i-te*, while the tribe next north of the Valley called it *Oo-soó-ma-te*.

For several years after the discovery of Yosemite Valley in 1851, only a few people visited it. In 1852, two mining prospectors were killed by Indians near the foot of Bridal Veil Falls. A punitive expedition of United States troops under Lieutenant Tredwell Moore entered the Valley, executed five of the Indians and pursued others across the mountains by Tenaya Lake and Bloody Canyon to Mono Lake. Gold was found on the eastern side of the range, and the news spread among the Fresno River camps. A party of miners, among whom was a man named Leroy Vining, visited the Mono region. Leevining Canyon was named at this time. James Caper Adams, the great grizzly bear hunter, camped just north of Yosemite in 1852 and visited the Valley in 1854.

The tourist history of Yosemite began in 1855 with the visit of James M. Hutchings and a small party. They were enthusiastic over the falls and cliffs and made these wonders widely known. In 1863 and 1864 the California State Geological Survey, under Josiah Dwight Whitney, explored Yosemite and the Tuolumne Meadows. Largely upon the recommendation of the Survey, the Valley was set aside by Congress "for public use, resort, and recreation," under the trusteeship of the state of California. The Valley remained under state administration until 1906, when it was consolidated with the Yosemite National Park, which had been constituted in 1890 from the surrounding territory, and has since then been under federal jurisdiction.

There is a great deal of interesting literature on the history of Yosemite which you can best learn about by inquiring at the Museum. The Park naturalist will be glad to show the books or give you references to them. The Government publications giving information about the Park can be had there or by writing to the National Park Service, Department of the Interior, at Washington.

Doctor Rixford—In dedicating this plaque to Doctor Lafayette Houghton Bunnell we must not forget the debt we owe to Doctor Howard A. Kelly of Baltimore, whose inspiration it was that gave birth to the idea of the medical profession commemorating in some fitting way the pioneering activities of Doctor Bunnell. Doctor Kelly learned that the grave of Doctor Bunnell in Winona, Minnesota, is unmarked, save for a G. A. R. emblem, and started a subscription list for a suitable monument for this "real medical pioneer." Moreover, Doctor Kelly contributed $50 towards defraying the expense of placing this plaque in Yosemite Valley, in memory of Doctor Bunnell, who "alone of the little group that entered on a punitory expedition went eager and thrilled with the zest of discovery. He fully appreciated the opportunity, and was filled with mystery. His companions were impassive and unimpressed, while he was exulting in the glories that unfolded before them: he became its baptismal sponsor and gave the Valley its euphonious name and later wrote about it in a never failing spirit of enthusiasm. For these reasons we claim that Doctor Lafayette Houghton Bunnell was the true discoverer about March 21, 1851."

Doctor Kelly was not aware that the date of entry of the Mariposa Battalion has been accurately fixed as March 25, 1851, as Bunnell himself was uncertain of the date. We have no knowledge of the circumstances which led Doctor Bunnell to write his book, "Discovery of Yosemite Valley and the Indian War of 1851 Which Led to That Event," but much of the vagueness of his description is doubtless explained by the fact that the book was written some thirty years later and after the Valley had become famous through the published writings of J. M. Hutchings.

Doctor Kelly became interested in Doctor Bunnell in a roundabout way through a letter published in the Medical Record, November 23, 1915, from Doctor H. S. W. Barnes of Santa Ana, California, calling attention to the regrettable omission of the name of Doctor Bunnell from an article in the issue of October 26 by Doctor William Browning, entitled "Some of Our Medical Explorers and Adventurers." By dint of much correspondence, Doctor Kelly finally secured and pieced together many items concerning the life of Doctor Bunnell, in addition to Bunnell's own published writings. His book on Yosemite, Doctor Barnes calls a "frontier classic," and his later volume, "Winona and Its Environs on the Mississippi in Ancient and Modern Days," is described as "a mine of Indian lore."

Doctor Kelly published the results of his search in Annals of Medical History, October, 1921, and this article is our principal source of information about Doctor Bunnell.

Bunnell was called *Doctor* because of his knowledge of medicine, but he had no diploma till long after his sojourn in California, when the La Crosse Medical College in 1864 gave him a diploma ("honorary"). The diploma issued by the college in the Republic of Wisconsin is preserved, and is in possession of the Minnesota Historical Society.

Born in Rochester, New York, November 2, 1824, his father a practicing physician, his mother a member of a distinguished family, Houghton by name, Bunnell spent most of his formative years in Detroit. Later, in La Crosse he attended clinics in the La Crosse Medical School, very much against his will. He was not interested in medicine. His was too much a roving disposition to settle down as a country doctor or even to make much of a success of business. But with scant systematic training his knowledge of medicine, derived largely by sheer observation and absorption from the medical atmosphere of his father's home, simply had to be drawn on for the benefit of his fellows who, as in the mining days of California, were often far out of reach of trained physicians. He was peculiarly and emphatically "médecin malgré lui."

In the second visit of the Mariposa Battalion to Yosemite, Bunnell had something of a medical equipment with him and received extra pay as surgeon to the expedition.

Bunnell served in the Mexican War in 1845 and in the Civil War as a hospital steward, and after he received his diploma was appointed first assistant surgeon, then surgeon, on his enlistment in the Thirty-sixth Wisconsin Infantry Volunteers.

Thus Bunnell was a veteran of three wars, in all of which his knowledge of medicine secured for him unusual opportunities and responsible positions.

He died July 21, 1903, at Homer, Minnesota, at the age of 79, and is buried at Woodlawn Cemetery, Winona.

Thus passed a strong man, whose life was an epitome of pioneering and adventure—the type of man who gave to California its peculiar character and romance—a type that did a great work and has passed on, and leaves one to wonder whether the inevitable huddling of humanity into great cities will, notwithstanding their vastly greater educational facilities, develop men of character which will ring as true.

MINUTES OF THE HOUSE OF DELEGATES, FIFTY-FOURTH ANNUAL SESSION OF THE CALIFORNIA MEDICAL ASSOCIATION.

FIRST SESSION

Held in the Tent, Yosemite Lodge, Yosemite National Park, California, Monday, May 18, 1925, at 8 p. m.

Call to Order—The meeting was called to order by the President, Granville MacGowan of Los Angeles.

Roll-Call—The secretary called the roll; forty-five (45) delegates were seated, and the president declared a quorum present.

Report of the President—The president, Granville MacGowan, stated that, as his report had been read in full to the association at the First General Session, he would therefore rule that no further report was necessary.

Report of the Council—James H. Parkinson of Sacramento, chairman of the Council, submitted the following report:

Doctor B. F. Keene—At the meeting of 1924, the report of the special committe on restoration of the grave of Doctor B. F. Keene, the first president of the society,

giving details as to specifications and costs of this work was received. The report was adopted and the committee continued with instructions to carry the work to completion. This has now been done and a brief sketch with an illustration appeared in the May number of CALIFORNIA AND WESTERN MEDICINE. It is impossible to read the minutes of the second annual meeting of the Medical Society of the State of California, February 11, 1857, or the obituary and resolutions appearing in the California State Medical Journal, October, 1856, and fail to realize that this, our first president, was of the highest type as man, physician and citizen. "A short biographical sketch," by Doctor Obed Harvey, then of Placerville, but later of Sacramento, whom several members of this society now living will recall, states that: "Four years he represented the County of El Dorado in the Senate of the State * * * * *, and had his life been spared one day longer he would again have been chosen." Of all that has been written, perhaps nothing better expresses the man as the true physician than this, probably from the pen of Doctor John F. Morse: "Although of a serious and grave cast of character, yet his heart seemed warmed towards his fellow-beings with a benevolence and confidence unmarred by suspicion and unaffected by the admonitions of experience." It is better that we depart hence while yet useful so that we be missed as well as regretted.

Bunnell Memorial

The special Committee on the Bunnell Memorial has, with the permission of Mr. Stephen T. Mather, placed a bronze plaque on a large boulder at the site of the first camp in the Valley of the Mariposa Battalion with the following inscription: "Commemorating Doctor Lafayette Houghton Bunnell, one of the first party of white men to enter the Yosemite Valley in March, 1851—he proposed the name Yosemite and was the first to proclaim its beauty and wonders to the world."

The plaque was designed by Mr. Paul Fair of Berkeley and fittingly depicts the grizzly (Yosemite), surprised at the entrance of the Caduceus, symbolizing the physician, into his native haunts. Doctor Bunnell, who had served in the Mexican War, was a member of the Mariposa Battalion organized January 18, 1851, as mounted infantry. This troop entered the valley by the "old Mariposa trail," and encamped near the meadow, now known as "Bridal Veil," on the south side of the Merced River and below the Bridal Veil falls. The plaque will be dedicated by the Society on Tuesday, May 19, at 10 a. m.

Meetings

The Council has held three regular meetings during the year; the daily sessions during the annual meeting not included. Two open meetings were held in connection with Industrial Medicine: one in Long Beach and one in San Francisco.

The Executive Committee has held nine meetings with an average attendance of six members out of eight.

Office of the Association

The office continues to function in a most satisfactory manner. The business of the association is conducted, apparently, with satisfaction to all who have come in contact with the staff.

It seems best to include in this report and to present each year certain tabulations which more graphically indicate conditions than is possible by any description. The following table shows the growth of the society for the ten-year period—1915 to 1924, inclusive, as of December 31.

Year	1915	1916	1917	1918	1919	1920	1921	1922	1923	1924
Membership	2557	2602	2699	2534	2496	3136	3484	3666	3809	3945

The Journal

California and Western Medicine continues to improve by the addition of special features and by a higher literary standard, which has been made possible by rigid selection from the abundance of material offered. To publish even the good papers that come to the office would make each issue an unwieldy volume. The request of the editor for an editorial reference committee was approved by the Executive Committee, and it is hoped by careful consideration to present, monthly, the best in medicine from the Pacific States. Doctor Musgrave, who has made these improvements possible, continues to serve without remuneration.

The following is a recapituation of Journal conditions from 1918 to 1924, inclusive:

Year	Yearly Pages Reading	Yearly Pages Advertising	$2 C. M. A. Dues	Miscellaneous Receipts	Disbursements	Yearly Profit	Yearly Loss
1918	540	552		$ 9,468.76	$10,908.57	$	$1,439.81
1919	446	576		11,011.99	11,472.89		460.90
1920	430	624		14,015.41	13,561.96	453.45	
1921	492	720		15,917.82	19,614.10		3,696.28
1922	468	768		18,202.91	21,877.21		3,674.30
1923	542	816		20,933.40	22,791.29		1,857.89
1924	720	816	$7,812	23,200.37	28,997.49	2,014.88	

Medical Defense

Medical Defense by the society ceased as of June 30, 1924. In order to keep before the society the imminent peril of damage suits, a condensed recapitulation of the medical defense feature for the years 1917 to 1924, inclusive, is here given:

Year	1917	1918	1919	1920	1921	1922	1923	1924	Totals for 8 Yrs.
Claims (threatened suits disposed of out of court)	44	28	22	17	23	28	24	19	205
Cases (disposed of by court proceedings)	22	17	12	17	17	7	13	22	127

The following is a statement for the year 1925 as of May 1.

	Defense Only	I. D. Fund
Claims (threatened suits) pending and undisposed of	6	8
Cases pending and undisposed of	23	35
Claims (threatened suits) disposed of out of court, 1925	0	0
Cases disposed of in 1925	11	4

Financial Condition of the Association

The financial condition of the society is sound. Even with the substantial sum of $7,812 credited to the Journal in accordance with the postal laws, the treasury shows a cash balance of $19,040.11 as of December 31, 1924. The books and accounts of the society were audited by Lester Herrick & Herrick, and according to their report on file were found correct. All claims are audited by the auditing committee, the bills being approved by that member of the staff responsible for them. The voucher is then approved by the secretary, signed by the auditing committee and countersigned by the chairman of the council and the secretary.

Annual Assessment

In view of our continued responsibility in connection with medical defense as well as other contingencies, it is recommended that the annual assessment be fixed at $10.

The following is a recapitulation in condensed form of the finances of the society from 1918 to 1924, inclusive, as of December 31 of each year.

RECEIPTS OF ASSOCIATION

Year	Amt. Dues	No. of Members	Society Dues	Journal Earnings	Miscl. C. M. A.	Total Receipts
1918	$ 7	2534	$18,157.00	$ 9,468.76	$3,019.08	$30,644.84
1919	7	2496	17,262.00	11,011.99	681.36	28,955.35
1920	7	3136	21,782.25	14,015.41	909.29	36,706.95
1921	8	3484	24,104.50	15,917.82	1,006.57	41,028.89
1922	8	3666	29,000.50	18,202.91	795.26	47,998.67
1923	10	3809	37,594.00	20,933.40	1,421.69	59,949.09
1924	10	3945	Net 31,346.00 Credit Journal 7,812.00	23,200.37	875.86	63,234.73

DISBURSEMENTS

Year	C. M. A. General Expense	Journal	Legal	Total	Cash On Hand Dec. 31
1918	$6,820.85	$10,908.57	$ 9,372.73	$27,102.15	$ 5,095.95
1919	6,543.22	11,472.89	9,294.36	27,310.47	6,740.83
1920	8,531.68	13,561.96	9,784.23	31,877.87	11,469.91
1921	9,018.28	19,614.10	17,839.82	46,472.20	6,126.60
1922	6,808.86	21,877.21	21,425.19	50,111.26	4,219.01
1923	4,543.57	22,791.29	22,243.42	49,578.28	14,589.82
1924	7,390.64	28,997.49	22,396.31	58,784.44	19,040.11

Optional Medical Defense

Optional Medical Defense inaugurated by the Council under instructions from the House of Delegates, went into effect July 1, 1924, for 168 members; on May 1, 1925, the number of subscribing members was 464. This, while most gratifying in every way, is not sufficient as a self-sustaining organization on the present financial basis. There should be at least 1000 members to afford a reasonable margin of safety. Until quite recently, no member has been sued. Three suits, however, have been filed during the present month and it is inevitable that others will follow. The former name of the society has been secured and perpetuated in the new organization.

Financial Impositions Upon the Profession

The committee appointed by the Council last year has shown commendable activity in an effort to obtain for the profession simple justice in the matter of these impositions.

Federal Income Tax—The bill amends Section 214 of Revenue Act of 1924 relating to deductions in computing net income by adding the words "or profession, or in attending professional conventions of the profession of which the taxpayer is a member." It will be recognized that this includes all professions. The Council has instructed the secretary to communicate with other professional organizations, and with all State societies and with the A. M. A. to ensure co-operation and general support.

Harrison Narcotic Tax—"Through the initiative of the American Medical Association, a bill was introduced in the 67th Congress, providing for the abolition of the war tax under the Harrison Narcotic Act, and its re-establishment on a peace basis."

Two Dollar Annual Tax—This has been under consideration by the Council and at the 144th meeting the League was authorized to introduce a bill repealing the $2 license tax and at the 74th meeting of the Executive Committee all action to repeal was deferred. What it actually means in real money to the members of the society is fairly well shown by the following table. It is assumed that the tax went into effect as of January, 1918. The membership of the society as of January 1, 1918, has been taken for that and succeeding years. On this basis a total of $46,140 has been paid by our members.

Year	No. of Members	Tax	Real Money
1918	2534	$2.00	$ 5,068.00
1919	2496	2.00	4,992.00
1920	3136	2.00	6,272.00
1921	3484	2.00	6,968.00
1922	3666	2.00	7,332.00
1923	3809	2.00	7,618.00
1924	3945	2.00	7,890.00
Total to date			$46,140.00

Proposed Amendments to Constitution and By-Laws

The attention of the Council was called to various conflicts between the constitution and by-laws and between the by-laws and council rulings. To harmonize the conflicting sections the necessary amendments have been submitted for consideration at this meeting. The principal change omits the controversial words "sciences allied to medicine" and keeps the California Medical Association limited in membership to Doctors of Medicine only. Associate members will be physicians who are engaged in research work or who hold federal positions, unlicensed to practice medicine in California, and hence ineligible to active membership. The requirements necessary for eligibilty to office in the society are also more clearly defined in the proposed amendments, which are published on page 896 of this issue of CALIFORNIA AND WESTERN MEDICINE.

Medical Officers' Reserve Corps

At the request of the Surgeon General, U. S. Army, the Council has appointed a statewide committee of fifteen on this subject, with Doctor John Wilson Shiels as chairman. The purpose of this committee is to aid in building up a medical officers' reserve corps under the general scheme of defense as devised and inaugurated by the War Department. The ultimate strength of the corps has been placed at 40,000. At this date 10,000 medical officers have enrolled. The Surgeon General will advise with the various state committees in classifying members in their respective states under the particular groups in which they are best qualified to function. In this way, it is hoped to avoid the mistakes that were inevitable, though most unfortunate for all concerned, during the World War. The committee will also serve as a point of contact between the army and medical profession, and as a means of communication between the Surgeon General and the California Medical Association. The chairman of the committee will present a report to the General Session Monday, May 18, 1925.

Industrial Medical Practice

At the 53rd Annual Session held in Los Angeles, May, 1924, the Council authorized the appointment of a statewide committee of 15 to investigate and report upon all phases of Industrial Medical Practice. This committee was organized into three regional groups, with Doctor Sol Hyman of San Francisco as general chairman of the committee. The committee held a conference with the Industrial Accident Commission on December 18, 1924, to discuss the new fee schedule contemplated by the Commission, and succeeded in deferring action in this matter. Two open meetings were held with the Council by this committee to discuss the progress made and to outline contemplated activities. On May 5, 1925, a post-card questionnaire was mailed by the committee to all members of the California Medical Association to ascertain those interested in industrial medicine. A formal report will be made by the chairman of this committee to the House of Delegates Monday, May 18, 1925.

Clinical Prizes

At the 148th meeting of the Council held in November, 1924, three clinical prizes were established to be competed for at the 1925 State Meeting as follows: First prize, $100; second prize, $75, and third prize, $50. The chair was authorized to appoint a committee of three to formulate the necessary regulations governing such awards. It was evident that the time was too short for competition in 1925, so no further action was taken. At a meeting of the Council held May 17, this action was rescinded and the recommendation made that two prizes only be offered of $150 each; one for original research and one for a clinical subject. If this be approved, the committee will be appointed.

History of the California Medical Association

At the 150th meeting of the Council held in February, 1925, the question of appointing a permanent committee on "Preservation of the History of the California Medical Association" was considered, and the chair was authorized to appoint such committee of from three to five members to include himself. This committee has not yet been appointed. The Council will endeavor to find men with the necessary knowledge.

Medical Radio Broadcasting

The possibilities of abuse in Medical Radio Broadcasting are so great and the need of some general rules for the guidance of our membership seemed so imperative that the Council appointed a committee to consider the question and to report. This committee, consisting of George H. Kress, chairman; Walter B. Coffey, Edward N. Ewer, Morton R. Gibbons and Granville MacGowan, submitted in February last a general report on the subject with the following specific recommendation:

"Your State Society Committee, therefore, recommends that each county unit be requested to provide for the appointment of a sub-committee on Medical Radio Broadcasting, this committee to consist of three to five members, according to the wishes of the county members; and the principles laid down in this report be carried out as fully as can be done according to the local environment."

The report was approved by the Council at its 150th

meeting, and has been transmitted to the component societies.

Prenatal Care

At the 53rd Annual Session held in May, 1924, the Council considered a series of letters then being sent out by the State Board of Health under the Shepard-Towner Act. After a conference with Doctor George E. Ebright, president, and Doctor Ellen S. Stadtmuller, director of Child Hygiene of the State Board of Health, a committee was appointed with Doctor Reginald Knight Smith of San Francisco as chairman, to formulate a pamphlet comprising the changes desired by the Council and the membership. The personnel of Doctor Smith's committee was selected from among the obstetricians and pediatricians of the State. The first draft of the proposed pamphlet was submitted to the Council at its February, 1925, meeting, and was deemed of such importance that it was mimeographed and mailed to each member of the Council for more careful consideration and recommendations. Copies were also mailed to obstetricians and pediatricians throughout the State for comment. The returned comments have been forwarded to the committee and a final report will be made at the General Session, Monday, May 18, 1925.

National Board of Medical Examiners

The recognition of the National Board of Medical Examiners by the California State Board of Medical Examiners is under consideration and is favored by the State Board. The matter is being taken up with the Attorney General.

Income Tax Deductions

Having heard the report of the President and of the General Counsel as to action taken with regard to the proposed amendment to the present Income Tax Act, the Council commends the action of the committee in the course adopted.

Permanent Convention Headquarters

The Council having heard the report of Doctor Harlan Shoemaker, chairman of the committee on Permanent Convention Headquarters, recommends that the thanks of the society be extended to the committee for the very large amount of work it has done, and that the committee be continued.

Appointment of Reference Committee—The president appointed as members of the Reference Committee Harlan Shoemaker of Los Angeles, chairman; O. D. Hamlin of Oakland and Fred R. Fairchild of Woodland.

Report of Auditing Committee—Morton R. Gibbons of San Francisco, acting chairman of the Auditing Committee, stated that the books of the association had been audited by Lester Herrick & Herrick of San Francisco, certified public accountants, who certified that all accounts for the year 1924 were correct. He then read the items of total receipts and disbursements for the year, and stated that the reports of the auditors were on hand and could be examined by anyone who desired to do so.

Report of Committee on Scientific Program—Emma W. Pope of San Francisco, as chairman, submitted the following report of the Committee on Scientific Program:

The program of the 1925 meeting reflects the careful work of section officers in the selection of diversified topics and of able speakers. It is a pleasure to acknowledge the exceptional co-operation of section officers for 1925.

There are certain facts that should be regularly emphasized in the report of the chairman of the committe on Scientific Program; the most important being that each annual program closes on February 15, goes to press March 20, and is printed annually in the April copy of California and Western Medicine. Long after the April journal, with its completed program has been published, applications for space come straggling into the office.

Every member who desires to speak at an annual session should apply to his proper section secretary before the first of any given year. The section chairman and secretary, acting in conjunction with the Program Committee, control the program of their section. In every issue of California and Western Medicine, the names of the section officers are listed, under the Directory of Medical Organizations.

All general meetings and many section meetings have as speakers invited guests. The names of Mr. W. B. Lewis, superintendent of the Yosemite National Park, and of Mr. Francis P. Farquhar of the Sierra Club on the Bunnell Memorial Program; of Doctor David Starr Jordan, president emeritus of Stanford University, on the League Program; of Doctor John Phillips from the Western Reserve University and Cleveland Clinic, on the program of the Fourth General Session; of the Honorable George F. McNoble, president of the California Bar Association, on the Optional Medical Defense Program; of Doctor Verne C. Hunt of the Mayo Clinic, on the General Surgery, Urology and Western Branch of the American Urological Association Sections; of Doctor Karl Meyer from the Hooper Foundation, on the General Surgery Program, are all names of men eminent in their various specialties. It is fitting that we make special acknowledgment to them for their interest and their part in making this the 54th Annual Session a success.

Report of Secretary—The secretary, Emma W. Pope of San Francisco, presented the following report:

The history of every individual, organization or nation is always a history of high-lights—of the times of great change, or stress, or conflict, or happiness. The quiet periods of even development go unnoted. In the history of the California Medical Association, 1924, is such an unemphasized period—a year of steady growth in membership, in accumulated working possessions, in society activities and in reserve funds.

The total increase in membership during 1924 was 173, which, depleted by 37 transferred and 35 deceased members, left a net total of 101. An increase of 361 members since the last apportionment of the A. M. A. made in 1922, entitled the California Medical Association to one extra representative in the body of 175 State delegates to our national organization.

During the year five 600-watt Bausch & Lomb lanterns and silesia screens were purchased for society use. These lanterns will eliminate much confusion at our annual meetings and will meet an urgent county society need in the extension service work. At this time, it is not inappropriate to state that no invitation is extended individually to members to join the Extension Service—all members are eligible. Notices have at times appeared in California and Western Medicine asking that those who desire to talk before county societies furnish this office the titles of those papers they are prepared to present, and whenever it seems warranted, new extension lists, including these names, will be printed and furnished to county secretaries.

The publication of a directory of the California Medical Association has met with hearty approval. The next issue, to be published in January of 1926, will list the home address and office and home telephone numbers. Needless to say, this will involve much additional labor, and complete and accurate information will be possible only through the individual co-operation of our members.

The restoration of the neglected grave of our first president, Doctor B. F. Keene, at the pretty little hillside cemetery of historical Placerville, and the placing in Yosemite Valley of a memorial plaque in honor of Doctor Lafayette Houghton Bunnell, were worthy society activities.

The report of the work of the Placement Bureau is never quite accurate, due to the fact that very often physicians whom we have placed, or doctors for whom we have secured assistants, fail to report to this office the final outcome of the Placement Bureau work. By accident only, do we at times learn that the physician has secured the position to which the Placement Bureau has sent him. We have, however, an accurate record from thirty-five physicians, ten nurses and two technicians. The value of this service to young graduates cannot be over-estimated. It is often the connecting link to the worthwhile licentiate between his college work and his established office. The attention of the membership is called to the large number of office assistants and laboratory technicians on file with the hope

that more members in need of nurses and technicians will avail themselves of the Society's Placement Bureau.

Optional Medical Defense has now at the close of its first year, one-third the membership that the Indemnity Defense Fund had at the termination of its seven years of existence. It is an interesting commentary that those members who are most keenly alive to the need for this service, as is evidenced by their membership in it, are also most keenly alive to the necessity of lessening the number of alleged malpractice suits, and plan an educational campaign among the members for the avoidance, whenever humanly possible, of the causes that lead to these alleged malpractice suits.

There has been added $4500 to the $14,500 on hand January 1, 1924, making a total reserve of approximately $19,000. The general society expense was increased by $2800, of which about $2000 was expended in the purchase of lanterns and in the publication of our directory—the remaining $800 being due to an increase in salaries and office supplies. Legal expense did not decrease as was hoped, but remained almost the same as that of 1923, though, through the expenditure of this amount, twenty-two court cases were disposed of in 1924 as against thirteen in 1923. Journal expenses were greatly increased due to the expansion of the Journal before the present raise in advertising rates had become effective. Because of the present postal ruling that one-half of the subscription price of a fraternal journal must be credited that journal, $2 per member, or $7800, was so credited and thereby shows a $2000 Journal gain for 1924. The new Journal advertising rates became effective January 1, 1925, and to May 1 had absorbed all Journal expenses but $261. It is, therefore, highly probable that the Journal, if not further enlarged, will report for the coming year a much greater Journal gain.

Of the 3945 members at the end of 1924, 3566 are reported in good standing as of May 1. These statistics are rather indicative of the fact that those opposed to the amount of dues must come from a very small minority of the California Medical Association. It is interesting to learn authoritatively of what other states are doing. The annual dues of Washington, D. C., and of Oregon lead at $20, Texas comes next with $15, Michigan, Kentucky, New York, Wyoming and California $10, Wisconsin $9. Dues in other states range from $3 to $10. "Ohio," and this I quote from Doctor Olin West, "with a very splendid organization and a good journal, maintains its annual dues at $5. It is to be remembered, however, that Ohio has a membership of more than 5000. The state associations that maintain their dues at the lowest figures—$3 or $4—are, as a general thing, not nearly so active as those with higher dues."

When a man erects a building he guards by insurance against the loss of his invested capital. Medical dues are just such insurance and protect the capital of the years and the money invested in your profession. Were there no medical associations to uphold the ethics and educational standards of the medical profession and to educate the public in scientific medical truth, the dark ages of medical empiricism and quackery would be upon us.

The officers of your association, at their own expense, attend all Executive Committee meetings and all Council meetings held throughout the year. They, who thus incur many times the financial indebtedness of the regular membership, patiently debate the question of the reduction of dues. Does it not seem fitting that the membership, who seldom question the cost of a good dinner, or the loss of a misshot golf ball, or the price of an adventurous jaunt into the wilderness, by approving once for all the policy of levying a yearly assessment a little in excess of actual needs sanction through this regular yearly reserve, the undertaking of such society activities as seem desirable and worthy in the eyes of your appointed representatives.

In conclusion, let me again emphasize that the State office is information desk, complaint department, placement bureau, membership, bookkeeping and advertising department and general utility office. In doubt or debate on any subject, write or visit your office. Explanation clarifies hazy understanding; sane discussion modifies antagonistic beliefs; and whether the belief of the member or of the office be changed, the resultant effect is beneficial and advantageous to the harmonious unity of the association.

Report of Editor—The president announced that, as the following report of the editor had been presented before the First General Session, it would not be read at this session.

The financial condition of CALIFORNIA AND WESTERN MEDICINE is shown in the annual statement of the California Medical Association. It is an encouraging one, and it ought to be still better from year to year in spite of the increasing cost of paper and printing and the very sharp increase in postal rates that recently became effective.

Growth of the magazine has been equally satisfactory in all other respects, as is indicated by the following figures:

Number of pages published in 1924 (Vol. XXII, 12 issues), 1536, 654 pages solid reading matter, sixty-six pages reading matter in advertising pages, 816 pages advertising, including directories of medical organizations, front cover, index pages, etc.

Average number of words to page, 1200, making a total of 864,000 words of reading matter, exclusive of advertising.

Circulation over 5000, and more widely distributed than ever before.

Number of contributors' articles published in 1924, 117.

Number of manuscripts on hand, accepted but unpublished, 105.

Number of manuscripts declined in 1924, nineteen. Many others have been returned to the authors with suggestions for more or less extensive revision and not all of these will come back to us.

In a word, CALIFORNIA AND WESTERN MEDICINE is now a metropolitan medical magazine widely read and widely quoted in other medical and even non-medical literature. This desirable situation has been brought about by the wise and liberal policy of the Council, Executive Committee, officers and employees of the California Medical Association, representing you, the owners of the magazine. *Your policies are fruitful chiefly because of a successful co-ordination of editorial, advertising and publishing forces.*

I want to invite your attention to these three fundamentals of successful publication because you as the owners of the magazine need to consider the problem with particular reference to its future.

My own work, although delightfully interesting and even entertaining, must eventually be passed on to someone else. It will require all of the time of an editor to do as they should be done the things that only the editor, who is unavoidably responsible for his publication, can do. I ask you to consider this matter carefully and make preparations to meet eventualities.

More than to any other factor the quality and continued growth of CALIFORNIA AND WESTERN MEDICINE is due to the unusual ability, hard work and loyalty of my assistant, Miss Sue Van Wagenen. Miss Van Wagenen handles entirely upon her responsibility all the routine pertaining to advertising; collecting; securing discussion, assembling and arranging for the publishers all contributors' essays; in co-operation with the publishers she solves that most difficult of problems, the *mechanics* of the Journal, and she discharges many, many other important functions which usually have the personal attention of an editor. She is overworked and inadequately remunerated. Both of these situations should be corrected, even when considered solely in the interest of CALIFORNIA AND WESTERN MEDICINE.

From a financial standpoint, advertising and service to advertisers is the most important function of any publication. Ours is most ably handled by Mr. L. J. Flynn in the western field and by the Co-operative Medical Advertising Bureau in the national field. Mr. Flynn devotes practically his entire time to CALIFORNIA AND WESTERN MEDICINE and Better Health Magazine. He has developed and is still developing profitable and highly desirable lines of advertising among western clients. Flynn not only sells advertising but service to

advertisers as well. In this he has the support of the editor and your executive committee. It is the eternal attention to advertising *service* by a competent representative that enables California and Western Medicine to carry the largest amount of ethical, carefully edited and censored advertising of any medical magazine published.

From an esthetic and general appeal standpoint, the most important problem of any magazine is one for the publishers. This problem is being, and has been, handled for over twenty years in a highly commendable manner by the James H. Barry Company, under the immediate supervision of Mr. William H. Barry, who serves us wisely and well without additional compensation as Superintendent of Publications.

However, beautiful settings, silver and service do not make a meal. Nor do comparable qualities make a magazine. The meal depends for satisfaction upon the food, and the magazine is dependent upon the quality and method of presentation of the matter supplied by its contributors. Thus the development of California and Western Medicine—or any other magazine—is primarily dependent upon the contributors. In this instance, upon you. The measure of the scientific value of the magazine and of success in general in the end, also must be measured by you, our readers, and I leave the matter there.

Problems—I could interest you and probably entertain you with some of the manifold problems of the editor, but this would be at the expense of brevity and therefore of the value of this report.

There is one problem of major importance—and it is your problem—about which I need your instructions. It is, what shall we do about the large number of contributions now on hand and the others that are arriving almost daily? As shown above we now have on hand accepted material enough—much of it already in type—to supply our publication in its present size for a year. In addition to this and aside from the scores of essays accumulated at medical meetings, the routine mail brings us ten or more papers a month, or about enough to keep us supplied. How shall we solve this problem? Shall we still further increase the size and consequently the cost of the magazine; shall we issue it more frequently, or shall we become much more discriminating in the material accepted for publication? This is your problem and you instructions as to policy are invited.

In my opinion—and it is only an opinion—the time is not ripe for a weekly or semi-monthly magazine; the size of each issue should be left entirely to the judgment of the editor and the executive committee; and the editor, with the advice of his Editorial Councilors, should be formally instructed to select and accept for publication only what can be used of the best and most appropriate from what is offered. This under such policies as the Council and Executive Committee may from time to time prescribe.

Assuming intelligent judgment and not over a reasonable amount of fallibility on the part of the editor and his advisors, this policy should lead to the production of a medical magazine of increasing usefulness and attractiveness. It does manifestly increase the problems and responsibilities of the editor. But that is what editors are for. The wise action of the Council in providing the editor with a confidential council of such fellows as he may elect helps, but does not eliminate, the grief inherent in accepting one author's work and declining that of another. The names of the editor's some fifty councilors are kept confidential between him and each advisor, for obvious reasons.

Report of Committee on Industrial Medical Practice—Sol Hyman of San Francisco, as chairman of the Committee on Industrial Medical Practice, presented the following report:

In speaking to you upon the work of the committee on Industrial Medical Practice, we shall at first endeavor to give you a brief review of the situation in this field as it exists in California at the present time.

Review of the Situation

From many interviews with men in and out of the industrial field your committee has found that the evils connected with this work, so far as the medical profession is concerned, fall into two main groups:

1. So-called unethical practices such as advertising, soliciting, establishment of dressing stations, use of unapproved cards, etc.

2. Fee cutting both by physicians and insurance carriers. In this group might also be placed overcharging.

The committee on Industrial Medical Practice, feeling that group two, fee cutting in all of its phases, is by far the more important issue, has directed its work along these lines.

The fee cutting evil presents itself in a variety of forms, the principal of which are:

1. Apparently charging according to the fee-schedule, but not entering all of the items, such as omitting a certain percentage of the visits made.

2. Taking cases upon a flat rate basis for certain groups of cases, the flat rate being based upon what the claims adjustors deem to be the average rates the carriers can pay.

3. An agreement to work for a given percentage rate of the fee-schedule.

4. Contracting to work for a certain percentage of the premiums.

5. Not charging in full for what is done, i. e., charging office rates for hospital visits, giving hospital attention at cost, omitting charges for repeated radiograms, dressings, etc.

6. Taking of employment by lay organizations.

7. Accepting salaries for responsible positions.

It is clear that all of these practices have but one end in view: To make such a showing with the insurance carrier so that, in so far as can be gotten by with it, the work will go to the physician or organization which is able to save the most money for the carrier.

It is also clear that the progressive application of the above lack of co-operation on the part of the members of the profession must inevitably, and has already done so, lead to the concentration of this work in the hands of a few organizations which, because of large volume and reduced overhead, can and do serve the insurance carriers in a manner to their financial liking. Let it not be understood that your committee is criticizing adversely the existence of either small or large organizations devoting themselves to industrial medicine. It is discussing such organizations which underbid the fee-schedule in order to obtain the work.

As a corollary of the practice on the part of members in our association of underbidding and competition there has naturally developed the employment of solicitors, the attempt by correspondence and otherwise to take the work away from those who have it and the numerous other practices which can be classified under the general group, unethical.

The state of affairs has been well expressed by one industrial surgeon, who said that the whole practice of industrial medicine is degrading, and that all that he can hope to do is to keep himself at the upper limits of degradation.

Insurance Carriers—The insurance carriers are now in an apparently controlling position strategically and come fairly close to being able to dictate the rates at which industrial medical practice shall be compensated. Where necessary or expedient full schedule rates are paid, and where not necessary or expedient they demand and receive medical attention to the injured workman upon a basis of flat rates, premium percentages, fee-schedule reduction and salaries. They are able to, and do, transfer the work from one man to another over night if the desired reductions are not made. They are unwilling to acknowledge the rising cost of the medical services in line with the rising cost of all other commodities. They are unwilling to recognize that they have become educated to the value of better and more extended medical services in order to lower their compensation payments, and that consequently more must be paid for such services. They are unable to reduce their overhead in the matter of rents, advertising, brokerage, office supplies and clerical help, but see a fertile field for reduction in medical fees and

cultivate it. Some of the companies recognize the value of high grade service, adequately compensated, and maintain medical organizations of the highest rank, while others are unable to see further than the ledger.

The State Compensation Insurance Fund, the company doing the largest business in the State, about 40 per cent of the whole, and which returns dividends to its policy holders, is making a definite campaign for more business based upon the premise that it furnishes medical services at a low cost and thus is able to return larger dividends to the advantage of the policy holders. The fund has in process of development a central hospital in Redding to serve nine northern counties, to which are to be sent all of the hospital cases in these counties—a not inconsiderable industrial area. This will not alone cause a great disturbance and loss to the medical community, in that many of the practitioners in this district have made large investments in hospitals and apparatus for the care of these cases, but there will result a definite dislocation in the social aspect of these communities. Well equipped young men cannot be expected to look to these fields in which to settle and become factors. Doubtless should this scheme eventuate successfully it will be inaugurated more or less throughout the State. It will probably reduce, in a measure, the cost of compensation insurance; but is it, after all, the most economical procedure all round for the people of these communities? Will those away from the location of the central hospital be as well cared for as heretofore? Is this difference in care worth the few dollars saved in compensation insurance?

From our numerous interviews we gather the impression that the State Compensation Insurance Fund arbitrarily cuts the fees more than does any other company. We cannot state this positively to be the fact, but we can state that the committee has received many, many more complaints concerning this company than that of any other. Much of the work previously in the hands of the Medical Director is now in the hands of a layman. We note particularly that attitude of this carrier because it is a public organization, whose existence is the result of a popular vote, and whose purpose in being brought into being was that of an upholder of standards.

The Industrial Accident Commission—The Commission was written into the Workmen's Compensation Act as an impartial body to represent the State, that is all of the interests involved in the application of the Act, and as the trustees of the State Compensation Insurance Fund. In the ordinary routine work, that of adjudication of claims, etc., the committee has not come in contact with the Commission.

Last December the Commission proposed a new and comprehensive fee-schedule based upon flat rates and weekly rates of compensation for medical and surgical services. At the request of this committee the point of view of the profession in opposition to this type of schedule was presented to the Commission. The hearing was attended by the representatives of organized labor who also voiced their opposition to flat fees and weekly compensation. The chairman of the Commission then assured us that no fee-schedule would be adopted without notification of and consultation with this committee, which in turn assured the chairman of its readiness to co-operate with the Commission at all times. To date there have been no futher meetings on this subject.

The campaign of the State Compensation Insurance Fund to acquire business on a basis of a more economical medical administration and the establishment of central hospitals to the general dislocation of social and medical order in the communities affected, we must assume have the sanction of the Commission as the trustees of this fund.

Labor—The man most vitally affected and in whose interest the Act was designed is the working man. The officers of the State Building Trades Council and Affiliated Unions and of the other State labor organizations assure us of their definite interest and willingness to co-operate with us in any effort to improve the medical services received by injured working men under the Act, They realize, however, that many of the problems are purely or mainly professional, and express themselves very certainly that any plan must come from within the profession and have its whole-hearted support. If the medical profession can present an undivided front then they are willing and ready, in the interest of the injured working man, to do their full share. They regard the problem as one affecting the whole State, but specifically the doctor and the injured working man.

The Plan—In attempting to pave the way for the plan submitted by your committee at previous meetings of the Council whereby it was hoped that industrial medical practice might be put on a proper ethical basis by means of co-operation among the insurance carriers, the public as represented by the Industrial Accident Commission and the medical profession as represented by this association, the committee has encountered an obstacle which it has been able but partially to surmount only in the last month. As previously reported the claims attorneys in the San Francisco (Northern California) jurisdiction have expressed themselves as in favor of the idea proposed and are ready to discuss with us the details for carrying the proposed scheme into effect; but we have up to very recently been unable to interest the claims attorneys of the Los Angeles (Southern California) jurisdiction sufficiently even to allow a representative of the association to come before them. Finally, by dint of repeated arguments, a meeting was arranged and several representatives of this committee appeared before their organization in Los Angeles and discussed with them our plans. Although the organization in San Francisco voiced its approval of the principles and objects of our scheme, the Los Angeles group expressed no opinion, but appointed a committee to deal with the matter. Here the matter stands at the present time. It is clear to the committee that whatever plan be adopted can only be effective and made to go if that portion of the medical profession interested in this type of work wants it, and wants it badly enough to sacrifice something for it. It is also clear to the committee that if the profession is able to present an undivided front, each man having the sincere and real backing of his entire group, that all rebating, fee cutting and dictation by the insurance carriers can be stamped out overnight. If the interested membership of this organization wants this, its committees can accomplish something. If it does not want it, its committees are useless and helpless.

The Ballot—In order to form some sort of an estimate of the tenor of feeling within the association a ballot was taken. Sixteen hundred and thirty-four ballots were returned, representing about 40 per cent of the membership of the association. Three hundred and ninety-eight declared themselves as not interested in industrial medicine; 1135, or about 98 per cent of those directly interested in this type of work, are willing to subject themselves to the actions and decisions of the association, while twenty-two, about 2 per cent, state that they are unwilling to have their freedom of action restricted. While this ballot is perhaps indicative, the committee is somewhat in doubt as to its true meaning because, while the vote was large, there remains always the question as to the feelings of the 60 per cent who did not return an opinion.

Possibly the percentage of those who state that they will not abide by the decisions of their group can be somewhat reduced after a better understanding of the problem, but we must be alive to the fact that very few non-conformists can wreck any plan that is based upon confidence and co-operation.

The general membership of the association had but little notion that this committee has been at work upon this problem until the ballot-cards were circulated.

Summary—The industrial medical situation is not alone critical; it is disagreeable and dirty. Within the ranks of our own profession are intrigue and connivance. There is no loyalty to group and no adherence to standards. Every man is for himself and the devil take the hindmost. The ethical standards, if such they can be called, of commerce are dominant. The end justifies the means.

The individual industrial physician says that he is driven to these extremes because the association gives him no support and does not discipline the malefactors. He cannot resist the tide single-handed. Driven by economic necessity he must fall into line. Competition

necessitates his lowering of standards, much as he deprecates it. He is of the opinion that a group of men meeting in this room have it in their power to pass some resolutions and create a millennium. He fails utterly to realize that any policy of this association can be instituted only when it is the policy of the membership.

This brings us to the crux of the situation. Can the Council or the House of Delegates, now and here, put into operation *any* formulated plan to which the members of this association will adhere? Is each and every individual member ready and willing and desirous to make the fight, for a fight it will be, for several years in order that the position of medicine in the industrial field be placed on a professional rather than a commercial basis, where it now is? The present situation is the creation, not of any California Medical Association, but of the members of that association. Its correction lies solely in the hands of these same members. Is our moral fibre such that a disagreeing minority will resign itself to the will of the majority? Are we sure enough of ourselves to know what we want and to go after it?

It would seem, from the ballot, that a large interested majority can answer these questions affirmatively. Can we be satisfied that this ballot is a true reflection of the attitude of the society? What is the attitude of the 60 per cent who did not answer?

So the situation as it stands today is thus: The principal evil in the industrial medical field is fee-cutting in one form or another. The blame lies within our own ranks. The result has been a tearing down not alone of medical, but of all standards, placing the insurance carriers in the control of the situation. The indications for the future are along the lines of intense concentration with still further reduced compensation, viz: Salaries. The remedy lies in our hands; application depends upon just one factor, the moral fibre of the membership of this association.

With all of the foregoing in mind, does the membership of this association really want the situation remedied? Can it present not alone in its statements but in its actions, an undivided front, an unbreakable phalanx? The answer to these questions your committee must have. It is time for the association to speak.

In order that those county units and sections who may wish to actively engage in attempting to remedy some of the abuses that now exist in Industrial Medical Practice, may have a general foundation of principles upon which to base their actions, the Committee of Fifteen on Industrial Medical Practice of the California State Medical Association recommend that the association take definite action, declaring the following practices as related to Industrial Medicine unethical:

1. Price cutting below the regular accepted fee-schedule either directly or indirectly.

2. Fee splitting of any kind, either directly or indirectly.

3. Rebating fees or any portion of a fee, either directly or indirectly.

4. The solicitation of business by lay or other employees.

5. The advertising by individuals or by hospitals other than that allowed by the code of ethics of the American Medical Association.

6. To be employed in any capacity either on salary, fee or retainer, or as consultant by any institution or corporation or group doing industrial medicine that is owned or controlled by laymen and operated for profit.

Should further questions arise, the committee stands ready to consider them and to present recommendations at subsequent Council meetings.

Report of Committee on Medical Officers' Reserve Corps—In the absence of the chairman, John Wilson Shiels of San Francisco, John Homer Woolsey of San Francisco, as a member of the Committee on Medical Officers' Reserve Corps, presented the following report:

San Francisco, California, May 15, 1925.

Meeting of the General Committee of the Medical Officers' Reserve Corps, present San Francisco Surgical Section as follows:

J. Wilson Shiels, M. D., Chairman, Colonel, 291 Geary street, San Francisco; Harry G. Ford, M. D., Colonel, University Hospital, San Francisco; Clarence Quinan, M. D., Lt. Colonel, 2512 Washington street, San Francisco; Walter H. Winterburg, M. D., Lt. Colonel, 516 Sutter street, San Francisco, and John Homer Woolsey, M. D., Major, 135 Stockton street, San Francisco.

Object—The education and information of the Medical Profession of the State of California relative to the National Medical Military affairs.

Program

(1) Inclination and better acquaintance between members of the committee.

(2) That the committee shall work at all times in close co-operation with the chief medical officer of the Ninth Corps area and request that he be a member ex-officio of this committee.

(3) It is the sense of the committee that there shall be a Medico-Military meeting at least once per year in each County Medical Society of the State. This meeting to be arranged for by the local representatives and aided by the State Committee.

(4) Request for a regular definite space in the Journal—"California and Western Medicine." This space will be filled subject to the approval of the editor of the Journal by the member of the State Committee appointed as a special editor.

(5) That one person be appointed within each County Medical Society by the General Committee subject to the approval of the respective County Medical Society president.

Unfinished Business—There was no unfinished business to come before the House of Delegates.

New Business—In accordance with the rules of the association, the following resolutions were presented and referred to the Reference Committee. For text of these resolutions and final action by the House of Delegates, see minutes of the second session.

Resolution No. 1. **Amendments to Principles of Medical Ethics of A. M. A.**—Presented by Harlan Shoemaker of Los Angeles.

Resolution No. 2. **Research in Intestinal Parasitism**—Presented by Lyell C. Kinney of San Diego for the San Diego County Medical Society.

Reading and Adoption of Minutes—The minutes of this session were read and, on motion of James H. Parkinson of Sacramento seconded by Joseph Catton of San Francisco, were approved.

Adjournment—There being no further business, the House adjourned to meet at 8 p. m. on Wednesday, May 20, 1925, in the same place.

MINUTES OF THE HOUSE OF DELEGATES SECOND SESSION

Held in the Tent, Yosemite Lodge, Yosemite National Park, California, Wednesday, May 20, 1925, at 8 p. m.

Call to Order—The meeting was called to order by the president, Granville MacGowan of Los Angeles.

Roll-Call—The secretary, Emma W. Pope of San Francisco, called the roll; fifty-eight delegates were seated, and the president declared a quorum present.

Place of Meeting for 1926—The chairman of the Council, James H. Parkinson of Sacramento, announced that by unanimous action of the Council, the invitation of the Alameda County Medical Society to hold the 1926 meeting in Oakland had been accepted.

Report of Committee on Arrangements—The chairman of the Committee on Arrangements, James H. Parkinson of Sacramento, announced that the number of members registered at 5 p. m. today was 387, and the number of persons in attendance at the convention 824; and that the number present at the 1922 meeting in the Valley was only 400. Doctor Parkinson read a letter from the Yosemite National Park Company expressing their appre-

WILLIAM TAYLOR McARTHUR
President-Elect 1925-1926

ciation at having the 1925 convention of the California Medical Association in Yosemite. He then requested the privilege of the floor for Doctor George Franklin Shiels of San Francisco, who was present at the personal request of Colonel Edward L. Munson of the Ninth Corps Area.

Medical Officers' Reserve Corps—George Franklin Shiels, as the personal representative of Colonel Munson, then addressed the House of Delegates briefly on the purpose and aims of the Medical Officers' Reserve Corps.

Election of Officers

President-Elect—William T. McArthur of Los Angeles was nominated for president-elect by William Duffield, Los Angeles. The nomination was seconded by Joseph Catton, San Francisco, who then moved that the nominations be closed; such motion being seconded by James H. Parkinson, Sacramento; and the secretary instructed to cast the ballot. The secretary cast the ballot, and the president declared William T. McArthur elected president-elect for the year 1925-1926.

Vice-President—Thomas F. Madden of Fresno was nominated for vice-president by Fred R. De Lappe, Modesto, such nomination being seconded by Lyell C. Kinney, San Diego.

Joseph Catton of San Francisco was nominated by Fred Rodenbaugh, San Francisco; such nomination being seconded by C. H. Church, Yosemite.

There being no further nominations, the president announced that the House would proceed to ballot, and appointed William Bowman, Los Angeles, and Charles L. Curtiss, Redlands, as tellers. Fifty-eight ballots were cast as follows: Joseph Catton, San Francisco, 32; Thomas F. Madden, Fresno, 26. The president then declared Joseph Catton elected vice-president for the ensuing year.

Councilors

Second District—William H. Kiger of Los Angeles was nominated by Harlan Shoemaker, Los Angeles, to succeed himself as councilor for the Second District. The nomination was seconded by Dudley Smith, Oakland. On motion of William Duffield, Los Angeles, seconded by H. A. L. Ryfkogel, San Francisco, the nominations were closed, and the secretary instructed to cast the ballot. The secretary cast the ballot, and the president declared William H. Kiger elected councilor for the Second District for the ensuing three years.

Fourth District—Fred R. De Lappe of Modesto was nominated by Church, Yosemite, to succeed himself as councilor for the Fourth District. The nomination was seconded by Harry E. Alderson, San Francisco. On motion of Morton Gibbons, San Francisco, seconded by Alderson, San Francisco, the nominations were closed, and the secretary instructed to cast the ballot. The secretary cast the ballot, and the president declared Fred R. De Lappe elected councilor for the Fourth District for the ensuing three years.

Eighth District—James H. Parkinson of Sacramento was nominated by C. B. Jones, Sacramento, to succeed himself as councilor for the Eighth District. The nomination was seconded by Fred R. Fairchild, Woodland. On motion of T. C. Edwards, Salinas, seconded by R. A. Terry, Los Angeles, the nominations were closed, and the secretary instructed to cast the ballot. The secretary cast the ballot, and the president declared James H. Parkinson elected councilor for the Eighth District for the ensuing three years.

Councilor-at-Large—O. D. Hamlin of Oakland was nominated by Dudley Smith, Oakland, for councilor-at-large to succeed himself for the ensuing three years. The nomination was seconded by R. T. Legge, Berkeley.

Robert Peers of Colfax was nominated by R. R. Newell, San Francisco, such nomination being seconded by R. T. McGurk, Stockton.

There being no further nominations, the president declared the nominations closed, and instructed the tellers, William Bowman, Los Angeles, and Charles L. Curtiss, Redlands, to collect the ballot. The secretary announced that fifty-five ballots had been cast as follows: Robert Peers, Colfax, 31; O. D. Hamlin, Oakland, 24. The president then declared Robert Peers elected councilor-at-large for the ensuing three years.

Member of Committee on Scientific Program—Roland E. Skeel of Los Angeles was nominated by Harlan Shoemaker, Los Angeles, as a member of the Committee on Scientific Program for the ensuing four years. William Duffield, Los Angeles, seconded the nomination, and then moved that the nominations be closed and that the president declare Doctor Skeel elected a member of the Committee on Scientific Program by unanimous action of the House of Delegates. The secretary cast the ballot, and the president declared Roland E. Skeel unanimously

JOSEPH CATTON
Vice-President 1925-1926

elected a member of the Committee on Scientific Program for the ensuing four years.

Delegates to A. M. A.—The chairman of the Council, Parkinson of Sacramento, advised the House it was impossible for the House of Delegates of the C. M. A. to elect delegates to the A. M. A. at this session and have proper representation at the National Convention and, therefore, the Council, at its 150th meeting held in San Francisco, February 14, 1925, had elected Hans Lisser of San Francisco to fill the unexpired term of T. C. Edwards, Salinas, who had resigned, and the Council had elected as delegates to the A. M. A. for the ensuing two years the following: Albert Soiland, Los Angeles; Robert V. Day, Los Angeles; Lemuel P. Adams, Oakland; and as alternates to the A. M. A. for the ensuing two years: Charles D. Lockwood, Pasadena; Robert Pollock, San Diego; O. D. Hamlin, Oakland.

Parkinson, Sacramento, then moved that the House of Delegates ratify and confirm the election by the Council of these delegates and alternates to the A. M. A. Alderson, San Francisco, seconded the motion. The motion was adopted unanimously.

Delegates to the A. M. A., with their corresponding alternates, are as follows:

Victor G. Vecki, San Francisco, 1925; alternate, C. Van Zwalenburg, Riverside, 1925.

Hans Lisser, San Francisco, 1925; alternate, William E. Stevens, San Francisco, 1925.

Albert Soiland, Los Angeles, 1925 and 1926; alternate, Charles D. Lockwood, Pasadena, 1925 and 1926.

Robert V. Day, Los Angeles, 1925 and 1926; alternate, Robert Pollock, San Diego, 1925 and 1926.

Lemuel P. Adams, Oakland, 1925 and 1926; alternate, O. D. Hamlin, Oakland, 1925 and 1926.

Report of the Reference Committee

Harlan Shoemaker of Los Angeles, chairman of the Reference Committee, presented the following report:

1. **Address of the President**—The address dealt, in a very timely manner, with the existing conditions of the profession and what constitutes the practice of medicine. Doctor MacGowan reviewed, in a broad way, the problem of industrial medicine and its relation to the profession. He surveyed the relation of chemistry and bacteriology to the clinical arts and gave prophetic advice regarding the Volstead Act. He paid a fine tribute to Doctor Lafayette Houghton Bunnell and Yosemite Valley. He touched on the subject of taxation upon the profession for professional expenditures, concluding a stewardship well performed.

2. **Address of the President-Elect** — The address is the story of the layman, cultural education and specialism. Doctor Ewer cleverly dissected the character of one of the late popular novels as an illustration of how a layman views cultural education in medicine and specialism. Quoting John J. Abel, "There should be in research work a cultural character, an artistic quality, elements that give to painting, music, and poetry their high place in the life of man," and deploring the cultivation of ultra specialism, the lack of the distribution of young doctors in rural districts, and suggesting some causes and corrections to equalize this great economic loss.

3. **Report of the Editor**—The committee recommends that the report be accepted and that the felicitations of the members, the House of Delegates, and the Council be extended to Doctor Musgrave for his indefatigable efforts in behalf of the California Medical Association and CALIFORNIA AND WESTERN MEDICINE, and that the problem of the Journal as to size and the frequency of the publication be referred to the Council for its recommendation.

4. **Report of the Legal Department**—The committee recommends that the report be accepted and the members, the House of Delegates, and the Council extend their commendation to our Honorable Counsel, and that it be the sense of this meeting that the publicity shall be combined with the active solicitation on the part of the members present to extend and fortify the Association on Optional Defense with the points, as suggested by Mr. Peart.

5. **Report of the Council**—The committee commends the report of the Council and recommends a topographical redistribution of the Councilor Districts that would give better contact with the Councilor and his District. The committee commends the compliance with the second-class postal laws for the support of the Journal. The committee notes with pleasure that the society is solvent, with a comfortable balance as of December 31, 1924. The committee commends the annual assessment of $10. The committee recommends the adoption of the amendments to the Constitution and By-Laws as read in the report of the Council.

6. **Report of Committee on Scientific Program**—The committee recommends that the report of the Scientific Program Committee be accepted, and urges greater cooperation of the other members of the committee with the secretary.

7. **Report of the Secretary** — The committee commends the report of the secretary and voices the unanimous approbation of the society.

8. **Report of Committee on Industrial Medicine**—The committee recommends, having in mind the factors of the foregoing report, that the acts of the committee be approved, and that the committee continue the preparation of a plan to correct the evils of industrial medicine and in addition that the rules appended to the aforesaid report be referred to the Council and the attorney for the association for codification and enforcement.

9. **Medical Officers' Reserve Corps**—The committee recommends that the report of Doctor John Wilson Shiels be adopted.

10. **Resolutions** — Resolution No. 1. **Amendments to Principles of Medical Ethics of the A. M. A.**—The text of the resolution is as follows:

WHEREAS, The Principles of Medical Ethics have antedated the histories of people among whom they were developed; and,

WHEREAS, The ethical relation of the doctor and patient cannot be prescribed by civil laws; and

WHEREAS, The conservation of the patient in life and death must always remain an ethical relation; and

WHEREAS, The public has never challenged the integrity of the medical profession in this delicate situation; therefore, be it

RESOLVED, That the Principles of Ethics of the American Medical Association, adopted by the House of Delegates at Atlantic City June 4, 1912, be extended and amended to include suitable penalties for the violation of these principles:

First—That these Rules of Ethics are hereby declared to be an integral part of the Rules and Regulations, Constitutions and By-Laws, governing each component county unit and scientific section.

Second—That the penalty prescribed for the violation of these ethics shall be censure, suspension, or expulsion, as the individual governing body shall elect.

Action by the Reference Committee — The committee recommends that the resolution regarding medical ethics be adopted, and that the notification of this act be made to the C. M. A. delegates to the A. M. A. by wire.

Resolution No. 2. **Research in Intestinal Parasitism**—The text of the resolution is as follows:

WHEREAS, The research in intestinal parasitism now being carried on in the Department of Zoology at the University of California is of exceptional interest to scientists engaged in the study and treatment of this disease; and

WHEREAS, Its significance in many forms of pathology render this research of rare value to human life and essential to the intelligent practice of medicine; and

WHEREAS, The members of the medical profession throughout the state are fully aware of the benefit they derive from this study of intestinal parasites, appreciating the urgency of the questions which Doctor Kofoid's work is answering; therefore, be it

RESOLVED, That the California Medical Association, in annual session assembled at Yosemite Park, hereby expresses to the Board of Regents of the University of California its sense of the value of this work, its profound appreciation of the data already promulgated by Doctor Kofoid, and its belief in the vital importance of his contributions to medical science; and be it further

RESOLVED, That this association holds, in view of the highly specialized human importance of Doctor Kofoid's work, that this research is one of the most valuable in-

vestigations in modern medicine, and that we urge upon the said regents that the university continue to extend to Doctor Kofoid every facility for the continuance and enlargement of his studies in human parasitology.

Action by the Reference Committee—The committee recommends that the resolution urging the Board of Regents of the University of California to further the work of Doctor Kofoid and the Department of Zoology, be adopted.

11. **Resolution on Appreciation to Yosemite Park and Curry Company**—The committee voices the sentiment of the association in a vote of thanks to the Lodge for the gavel made of native manzanita presented at this meeting. It further voices the appreciation of the members for the courteous service and the kind consideration shown to all the members and their families, during this meeting in the following resolution:

RESOLVED, That the thanks of the California Medical Association be tendered the Yosemite Park and Curry Company for the very handsome gavel presented to the association; and for its many courtesies and extraordinary efforts in making the meeting a success under most trying weather conditions; and, further, that the association particularly desires to thank Mr. R. E. McCormick for the large share his unfailing efforts contributed in making the meeting a success.

12. **Resolution of Appreciation to Doctor Howard A. Kelly**—The Reference Committee presented the following resolution:

RESOLVED, That the California Medical Association expresses its appreciation to Doctor Howard A. Kelly of Baltimore, Maryland, for his suggestion, interest and material help in placing in Yosemite Valley a plaque to "commemorate Doctor Lafayette Houghton Bunnell, one of the first party of white men to enter the Yosemite Valley in March, 1851. He proposed the name Yosemite and was the first to proclaim its beauty and wonders to the world."

13. **Resolution of Appreciation to National Park Service**—The following resolution was submitted by the Reference Committee:

RESOLVED, That the thanks of the California Medical Association be tendered Mr. Stephen T. Mather, Director of National Parks, and Mr. W. B. Lewis, Superintendent of Yosemite National Park, for their many courtesies, and especially for their most helpful assistance in connection with the dedication of the Lafayette Houghton Bunnell Memorial in Yosemite National Park.

14. **Resolution of Appreciation to Francis P. Farquhar**—The following resolution was submitted by the Reference Committee:

RESOLVED, That the thanks of the California Medical Association be tendered Mr. Francis P. Farquhar for his most able and interesting talk at the Lafayette Houghton Bunnell Memorial exercises, and for his beautiful and instructive exhibition of Sierra scenes.

15. **Yosemite Hospital**—The following resolution was submitted by the Reference Committee for R. G. Duffey of San Rafael.

WHEREAS, The hospital in the Yosemite National Park is inadequate for the present needs of the visiting tourists and traveling public; and

WHEREAS, The aforesaid hospital buildings are antiquated, out of date, unhandy and dangerous to all inmates in case of fire; and

WHEREAS, The travel into the Park is constantly increasing and the present buildings are not fit for expansion, being neither liveable in the winter and only partly comfortable in the summer; and

WHEREAS, FURTHER, There is an increasing and greater demand for a first-class medical and surgical service on the part of the visiting public from all over the United States which cannot be given in the present buildings; therefore, be it

RESOLVED, That the California Medical Association in regular session assembled exert its efforts in every possible manner on both the United States Congressmen and United States Senators in support of measures seeking an appropriation for the building of an adequate and well-equipped hospital in the Yosemite National Park.

On motion of Harlan Shoemaker, Los Angeles, seconded by Dudley Smith, Oakland, the report of the Reference Committee, which had been read section by section, was then unanimously adopted as a whole.

Resolution of Appreciation to the Honorable George F. McNoble—On motion of Parkinson, Sacramento, unanimously seconded by the House of Delegates, it was

RESOLVED, That the sincere thanks of the California Medical Association be tendered the Honorable George F. McNoble of Stockton, President of the California Bar Association, for the extremely interesting and very valuable address made by him on Tuesday evening on the relationship of the physician and his patient.

The president called upon Mr. McNoble, who then addressed the House of Delegates.

Expression of Appreciation by the President—President MacGowan addressed the House of Delegates, briefly expressing his appreciation for the honor conferred upon him the preceding year and the pleasure derived from his presidential duties.

Presentation of the President—The president appointed Pauline Nusbaumer, Oakland, and Robert Pollock, San Diego, to escort the incoming president, Edward N. Ewer of Oakland, to the chair. Doctor Ewer was then escorted to the chair by Doctors Nusbaumer and Pollock.

Presentation of the President-Elect—The president-elect, William T. McArthur of Los Angeles, was escorted to the platform by William Duffield, Los Angeles, and Harlan Shoemaker, Los Angeles.

Reading and Adoption of Minutes—The minutes of this session were read and, there being no objection, were unanimously approved.

Adjournment—There being no further business before the House, the meeting adjourned to meet in Oakland in 1926.

SECTION ACTIVITIES OF THE C. M. A. AT THE 1925 ANNUAL SESSION

(Abstracts from Minutes of those sections whose secretaries have sent in their reports)

General Medicine Section—This section held the usual three meetings under the chairmanship of Ernest S. du Bray of San Francisco; Roy E. Thomas, Los Angeles, secretary. The scientific program was carried out very much as published in the April issue of CALIFORNIA AND WESTERN MEDICINE. Many of the papers, carefully discussed and edited, will appear during the year in CALIFORNIA AND WESTERN MEDICINE.

The chairman's address on "Comments on Body Weights in Relation to Health and Disease" will appear elsewhere in this issue, as will all other addresses of chairmen that have been received by the editor in time for publication.

At the business meeting of the section, Roy E. Thomas, Los Angeles, was elected chairman and J. Marion Read, San Francisco, secretary for the ensuing year.

General Surgery Section—This section held three meetings under the chairmanship of Wallace I. Terry, San Francisco; C. T. Sturgeon, Los Angeles, secretary. The published program was followed very closely, and a number of the papers presented, together with carefully prepared discussion, will appear in due course of time in this Journal.

At the business session of the section, T. O. Burger, San Diego, was elected chairman; E. L. Gilcreest, San Francisco, vice-chairman; J. H. Woolsey, San Francisco, secretary, and J. H. Breyer, Pasadena, assistant secretary for the ensuing year.

The following resolution was introduced, but overwhelmingly defeated:

RESOLVED, That the Surgical Section petition the Council of the California Medical Association to consider the question of appointing a committee for standardizing the preliminary qualifications of medical men in their initial attempts to do major surgery.

Pathology and Bacteriology Section—This section held three meetings under the chairmanship of Newton

Evans, Loma Linda; Roy W. Hammack, Los Angeles, secretary. Some of the papers presented before this section, in accordance with the published program, will appear in CALIFORNIA AND WESTERN MEDICINE, and others in more special journals.

At the business meeting F. R. Nuzum, Santa Barbara, was elected chairman and Roy W. Hammack, Los Angeles, was re-elected secretary.

The section discussed the advisability of continuing a separate section on pathology and bacteriology, but no action was taken.

Industrial Medicine and Surgery Section—Two meetings were held under the chairmanship of Philip H. Stephens, Los Angeles; Packard Thurber, Los Angeles, secretary. This section followed quite closely its printed program in scientific work. A number of the papers, with adequate discussion, will appear during the year in CALIFORNIA AND WESTERN MEDICINE.

At the business meeting Fred R. Fairchild, Woodland, was elected chairman and Charles E. Von Geldern of Sacramento was elected secretary for the ensuing year.

The report of the Committee of Fifteen on Industrial Medicine Problems, under the chairmanship of Sol Hyman, was discussed. Abstracts of this report will be published when released by the Council.

Radiology Section (Including Roentgenology and Radium Therapy)—The section held three sessions under the chairmanship of Ray G. Taylor, Los Angeles; Robert Newell, San Francisco, secretary. The scientific program practically as published was carried out, and some of the papers will eventually appear in this Journal, and others, no doubt, elsewhere.

At the business meeting F. H. Rodenbaugh, San Francisco, was elected chairman for the ensuing year; R. G. Van Nuys, Berkeley, vice-chairman, and C. H. Parker, Pasadena, secretary.

The section discussed plans and policies for the ensuing year, and there was a general feeling that "more of the work of the section should be called before the general medical and surgical meetings," but no definite action was taken.

Neuropsychiatry Section—Two meetings were held by this section under the chairmanship of Glenn E. Myers, Los Angeles; Joseph Catton, San Francisco, secretary. The published program was carried out, with a few minor exceptions.

At the business meeting Joseph Catton was elected chairman and Carl W. Rand, Los Angeles, secretary for the ensuing year.

A motion was made authorizing the appointment of "a neuropsychiatric council of at least five members of the section, representative of the various portions of the state. Its duties to be to act for the section during the interval between annual meetings; to study certain problems, and suggest legislative ethical and other means of dealing with them; to devote its special attention during the coming year to the subjects of commitment of the 'insane' and expert medical testimony."

Urology Section—Three meetings were held by this section under the chairmanship of Frank S. Dillingham of Los Angeles; Miley B. Wesson, San Francisco, secretary. The scientific program was carried out largely as published.

At the business meeting Miley B. Wesson, San Francisco, was elected chairman and H. A. Rosenkranz, Los Angeles, secretary for the ensuing year.

The secretary reports prompt attendance at the meetings and strict enforcement of the length of time a speaker might occupy. Two of the essayists did not appear; neither did they send any notification either before or since, and therefore, according to Rule 9, they are automatically barred from presenting a paper before this section for two years. "We limited," says the secretary, "each paper to fifteen minutes, and notified each man at the end of his fifteen minutes that he had one minute. If the audience seemed restless, he was promptly stopped at the end of the minute, whereas if the audience was very much interested we stoppd him at the end of five minutes. When a man had lantern slides or was making numerous side remarks not especially connected with his subject, he was notified at the end of eleven minutes that he had four minutes, giving him an opportunity to condense and finish his paper. Those who discussed a paper from the floor were stopped promptly at five minutes. All members present seemed to be in accord that the section meeting was one of the most successful ever held; every member had been solicited for a paper, every paper submitted was accepted; no paper was allowed to run sufficiently long to tire the audience. Doctor Dillingham was a very considerate and politic chairman and conducted the meeting so that it ran smoothly and rapidly, giving satisfaction to all present."

Eye, Ear, Nose, and Throat Section—During the three sessions of this section, under the chairmanship of Ernest W. Fleming, Los Angeles; Percival Dolman, San Francisco, secretary, the scientific program was carried out as published with a few changes, and some of the papers read will be published in CALIFORNIA AND WESTERN MEDICINE during the coming year.

"The chairman in his annual address reviewed some of the important problems which confront the eye, ear, nose, and throat practitioner of today," says the secretary. "Each one of these problems, too small in itself for review in a separate paper, was briefly discussed in a few paragraphs. The entire grouping of subjects formed a practical guide to the specialist in solving many obscure problems of his work."

At the business session W. H. Dudley, Los Angeles, was elected chairman and Percival Dolman, San Francisco, was re-elected secretary for the ensuing year.

In the absence of Chairman George K. Kress of the Legislative Committee, Secretary Dolman made a report of the activities of the committee. This report was supplemented by Otis Allen Sharpe and Arthur Hebert, who had been active in Sacramento in legislative work.

The following resolution was unanimously adopted:

BE IT RESOLVED, That this Section expresses its grateful appreciation of the magnificent support given by the League for the Conservation of Public Health to Senate Bill No. 201.

BE IT FURTHER RESOLVED, That a copy of this resolution be forwarded to the League for the Conservation of Public Health by the Section secretary.

A resolution was adopted thanking the Legislative Committee for its excellent work during the past year.

Technical Specialties Section—Both the California Association of Medical Social Workers and the California Association of Physiotherapists, who together form the present membership of the Section on Technical Specialties of the California Medical Association, held meetings. Ray Lyman Wilbur is chairman of the section and John C. Wilson, Los Angeles, secretary.

California Association of Medical Social Workers—At the scientific meeting a splendid program of five papers was presented. Most of these papers will be published during the year.

At the business meeting Edna J. Shirpser, San Francisco, was re-elected president; the position of vice-president is to be filled at the June meeting and is to be the chairman of the Southern California section. Sophie H. Mersing, San Francisco, was re-elected secretary-treasurer. Rose Steinhart, San Francisco; Alice M. Keene, San Francisco, the secretary of the Southern California section (to be elected at the June meeting), and Helen Leonard, San Francisco, were elected directors.

First steps toward amending Article III, Section 2, of the by-laws to read: "Applicants for active membership not graduated from an accredited college or school giving training in social service work shall be eligible by furnishing an equivalent satisfactory to the Advisory Council, consisting of *two years'* successful medical social work under approved medical supervision."

California Association of Physiotherapists—In the absence of Ray Lyman Wilbur, M. D., president, and John C. Wilson, M. D., secretary of the Technical Specialties Section, C. L. Lowman, M. D., Los Angeles, opened the fifth annual meeting of the California Association of Physiotherapists, member of the Section on Technical Specialties, with an address emphasizing the importance of keeping up a high standard so that this association will always be a credit to the C. M. A. The program as published was carried out with minor changes, and at the close of the evening Robert E. Ramsay, chairman of the Pediatric Section, gave a short talk

on his growing interest in physiotherapy and how his appreciation of its value had increased.

The following officers were elected for the coming year: Beulah Rader, San Francisco, president; Florence Burrell, Oakland, vice-president; Mabel Penfield, San Francisco, secretary-treasurer. Hazel Furscott, Beret Stenwig, and Margaret Blake were elected as members of the Executive Committee.

Pacific Coast Association of Anesthetists—This association held its fourth joint meeting with the Section on Anesthesiology of the C. M. A., Caroline B. Palmer, San Francisco, president, and Eleanor Seymour, Los Angeles, secretary. After a very successful scientific meeting, a business session was held, at which R. F. Hastreiter of Los Angeles was elected president, Louise Oldenbourg, Berkeley, vice-president, and Eleanor Seymour, secretary.

The following resolutions were adopted:

1. RESOLVED, That an expression of sincere appreciation be sent to the California Medical Association for the many courtesies so graciously extended by its efficient officers to the Pacific Coast Association of Anesthetists.

2. RESOLVED, That an expression of appreciation be forwarded to the secretary of the Los Angeles County Medical Association for courtesy in publishing our announcement and program in the County Bulletin.

3. RESOLVED, That a return wire of acknowledgment and appreciation be sent to Dr. F. H. McMechan, including greetings to the Congress of Anesthetists in Atlantic City.

4. RESOLVED, That an expression of regret be sent to Dr. Mary E. Botsford for her unavoidable absence.

5. RESOLVED, That we commend the recent ruling made by the Council on Medical Education and Hospitals of the A. M. A., to the effect that in all teaching hospitals proper equipment and facilities be provided for the instruction of interns in anesthesiology and that such instruction be given by staff members who are graduate physicians proficient in this special field.

6. RESOLVED, That this Association reiterates its stand, deploring the employment of nurse and lay anesthetists, and endorses the attitude of the Council on Medical Education and Hospitals of the A. M. A., favoring only physician anesthetists.

7. RESOLVED, That we urge that all hospitals and anesthetists keep systematic records of all anesthetics administered.

8. RESOLVED, That a demand be made of manufacturers and hospitals to provide pure and fresh anesthetic agents at all times.

CONSTITUTION OF THE C. M. A.

First of two required publications of proposed amendments, to be voted upon by the House of Delegates 1926 session.

Amend the Constitution, Article III, Sections 1, 2, 3, 4 and 5, to read as follows:

ARTICLE III

MEMBERS AND GUESTS

Section 1. Members—The members of the association are the members of the component county societies and include all the active, associate and affiliate members thereof. Every member of the California Medical Association (hereafter elected) must hold the degree of Doctor of Medicine from an institution of learning accredited at the time of conferring such degree by the American Medical Association, and must be elected to membership by the component county society of the county wherein he resides, and pay all dues to the secretary of his county society.

Section 2. Active Members—Active members shall be elected from those Doctors of Medicine licensed to practice medicine and surgery in the state of California, who in the judgment of the component county society of the county of residence thereof, are deemed of such ethical integrity as is required for such membership. (Except if he lives on or near a county line a member may, with the previous written consent of the county of his residence, join the society of the county most convenient for him to attend, and such adjoining county shall be included in the term "county of residence" as herein used.)

Section 3. Associate Members — Associate members shall be elected from those Doctors of Medicine engaged in teaching or research work or holding position in federal service or otherwise, who are not licensed to practice medicine and surgery in the state of California and hence are ineligible to active membership. These members shall have all the rights and privileges of active members, except the right to vote or hold office. Their dues to the State Association shall be one-half the dues of active members, and their dues to their county society shall be fixed by such county society.

Section 4. Affiliate Members—Affiliate members shall be elected from those Doctors of Medicine eligible for active membership, but who are, for any reason satisfactory to the county society and the council of the State Association, entitled to special consideration. These members shall have all the rights and privileges of other members, except the right to vote or hold office. Their dues to the State Association shall be $1 per year, and their dues to their county society shall be fixed by such county society.

Section 5. Honorary Members—Honorary members of the California Medical Association may be elected by the House of Delegates.

Amend the Constitution, Article VI, Section 4, to read as follows:

ARTICLE VI

OFFICERS

Section 4. No delegate during his term of service as delegate shall be eligible to any office named in Section 1, except that of Councilor, and no person shall be elected President, President-Elect, Vice-President and Councilor who has not been a member of the association for two years preceding his election. Every delegate and alternate to the House of Delegates of the California Medical Association must have been a member of the association for one year prior to his election.

Amend By-Laws, Chapter I, Section 1, to read as follows:

BY-LAWS

CHAPTER I

Section 1. All members of county societies—active, associate and affiliate—shall by virtue of such membership hold corresponding membership in the California Medical Association upon certification by the secretary of the county society of such membership and receipt by the secretary of this association of the assessment for the fiscal year.

Amend the By-Laws, Chapter I, by adding a new section to be numbered 5, reading as follows:

Section 5. A member who changes his residence from the county through whose society he holds membership in this association to another county in which there is a county society, is eligible to membership in the component county society of his new residence on the presentation of a transfer card, and an official statement that his dues have been paid in full in the society in which he holds membership; provided that no evidence which would otherwise disqualify him for membership arise. He shall forfeit his membership in this association one year after change of location unless he becomes a member of the society of the county to which he has moved. Any member who has heretofore changed his residence as aforesaid shall have one year after the date of the adoption hereof to comply with the provisions of this section.

Amend the By-Laws, Chapter VII, Sections 4 and 14, to read as follows:

CHAPTER VII

Section 4. Each county society shall judge the qualifications of its members. However, as such societies are integral parts of this association and all the basis of membership in the American Medical Association, it is necessary that the qualifications meet the minimum requirements of the state and national organizations. These

minimum requirements are that, to be eligible for election as an active or affiliate member, the applicant must hold the degree of Doctor of Medicine from an institution of learning accredited at the time of conferring such degree by the American Medical Association, and must be licensed to practice medicine and surgery in the state of California. Every associate member must hold the degree of Doctor of Medicine from an institution of learning accredited at the time of conferring such degree by the American Medical Association, and must not be licensed to practice medicine and surgery in California and hence be ineligible to active membership. A member must not practice or claim to practice or lend his support, co-operation or in any other way endorse any exclusive system of medicine or any person practicing the same. He shall be honorable and ethical in his conduct and shall subscribe to the principles of medical ethics of the American Medical Association, and shall recognize the council of this association as the proper authority to interpret any doubtful points in ethics. Every applicant for membership in a county society shall fill out and sign in duplicate the application blanks provided by the society which prescribe the necessary qualifications for membership. One copy of each such application shall be promptly forwarded to the office of this association.

Section 14. Any county society may, in its discretion, elect active, associate, and affiliate members under and pursuant to the provisions of Article III of this Constitution. Any county society may also elect honorary members of its own society, but such honorary members shall not thereby be honorary members of this association.

ALAMEDA COUNTY

Alameda County Medical Association (reported by Pauline S. Nusbaumer, secretary)—The meeting of the association was held Monday evening, May 11, President Mehrmann in the chair.

A. A. Bird reported a case of megacolon in a boy 3 years of age, with exhibition of patient and lantern slides.

M. L. Emerson reported a case of obstruction of the bowel, with roentgenological studies.

The following program was then presented by the staff of Alameda County Hospital:

"Demonstrations of Pathological Specimens," by Gertrude Moore and N. A. Cary.

J. W. Calkins demonstrated with lantern slides and a model the operation for strabismus with modified Calkins' muscle folder. By means of this instrument, a simple method of shortening any of the external muscles of the eye is possible. The amount of shortening can be accurately graduated. The muscle is not cut, but is folded about the hairpin-shaped portion of the instrument one or more times as required to correct the deviation. The placing of the suture is simple, accurate, without danger of slipping or cutting through the sutures. Hayward G. Thomas opened the discussion of this paper.

E. W. Goodman's paper was a "Case of Spinal Cord Lesion Illustrating Advantages of Puncture of Cisterna Magna." Following a description of the technique of puncture of the cisterna magna and a resumé of the indications for this procedure, the doctor discussed the comparative values of the injection of lipiodol into the cisterna magna and of the study of different conditions of and chemistry in the fluid in the cisterna magna and the lumbar subarachnoid space. Two cases were then cited in which these maneuvers were carried out; in the first one they aided in the diagnosis of a neoplasm within the spinal canal which developed with most unusual rapidity, and in the second the level of a nervous block, due to a strong fibrous band following meningitis four years ago, was definitely shown by the obstruction to the downward passage of the lipiodol. The discussion of this paper was opened by J. E. Royer.

D. N. Richards presented a "Case of Hirschprung's Disease Improving Under Surgical Treatment" in a boy 12 years of age. The patient was first admitted to the Alameda County Hospital March 6, 1923, complaining of abdominal distension since birth and difficulty in moving bowels. X-ray examination of colon by means of barium enemas showed an enormously dilated large intestine. Exercise and cleansing enemas were given, and the boy was discharged. Second admission, August, 1924. Condition worse than before. Exploratory operation, August 11, 1924. Unable to outline the length of the tumor, so a simple colostomy was done. Patient sent home and readmitted October 27, 1924. Colostomy had closed. Numerous x-rays were taken to demonstrate the exact location of the dilatation, and it was found to be upper rectum and sigmoid. It had improved a great deal under this treatment. Second operation, December 6, 1924. Complete exploratory, demonstrating great hypertrophy of the intestinal wall. Loop of descending colon above dilatation was brought out and stitched to itself, according to Mikulicz's technique; colostomy established. Last x-ray picture was on April, 1925, and showed a barium fecalith in dilated portion of the intestine. Colostomy functioning well, and boy greatly improved. C. L. McVey opened the discussion.

Among other things in his paper, "Insanity as a Defense for Crime," C. W. Mack said: "It is a healthy sign that the medical profession is taking an interest in public welfare work as never before, and in doing so they cannot help but become involved in the study of individuals handicapped by mental disabilities and behavioristic problems. Psychiatry is an integral part of medicine, and its roots should be firmly grounded in orthodox practice. Psychiatry can do a great deal to help in the forward movement by contributing a study of psychopathic personalities in those afflicted with actual mental disease. A certain amount of disapprobation has been placed upon psychiatry of late because of spectacular trials that are so gruesomely represented in the newspapers—one recently in San Francisco and one in Chicago. It is not desired to take up the time of this discussion by condemning the men whose names receive so much prominence or to put forth a defense of psychiatry, as none is needed. It might be timely, however, to point out that lawyers may disagree in court without incurring any disrepute, but when doctors disagree the public naturally thinks that one side or other is falsifying for the sake of monetary profit. No psychiatrist wishes to go into court and, undoubtedly, psychiatrists as a whole have just as much honesty as any other branch of the medical profession. There is no thought in the minds of psychiatrists to secure freedom from punishment for criminals, but on the contrary they are less sentimental than the public at large. Modern psychiatry contends that there is a large element of feeble-mindedness or mental disease which accounts for a large share of the criminality. This is indicated by the fact that 60 per cent of prisoners examined show mental abnormalities which are largely responsible for the criminal tendencies. It is also worthy of note that 66 per cent of prisoners are recidivists. The present penal system is not diminishing the enormous wave of crime. The homicides in the United States in one year were 9500, whereas in Great Britain during the same period there were only sixty-three. The number of the executions out of the 9500 was only 114. In view of the fact that many criminals must be such because of their mental abnormality, they should remain in custody in a hospital throughout their entire life if necessary, or until such time as they are not a further menace to society, rather than be sentenced for a few months or years to a prison and then released. In other words, if certain types of criminals are, upon examination, found to be in such a mental condition that reformation is impossible, permanent segregation from society is what psychiatrists advocate, and they are not busying themselves in an effort to secure the acquittal of these criminals in court. The present position of doctors as experts in court is almost untenable. The new law recently adopted in Massachusetts would make it possible for physicians to be of some use to courts in handling delinquent individuals. This law makes it mandatory upon the clerk of the court where a prisoner is to be tried to notify the State Department of Mental Diseases, which department, in turn, appoints a board of examiners to determine the mental condition of the prisoner. This commission is given the larger duty also of discovering the presence or absence of any mental disease or mental defect and does not confine itself to a statement of whether or not the individual is sane or insane. This report is filed with the clerk of the court and is accessible to both the prosecution and the defense. There seems to be no

doubt but what the creation of similar legal machinery in this state would be much to our credit."

Others taking part in the discussions of these papers were Roderick O'Connor, O. D. Hamlin, R. G. Graham, and E. N. Ewer.

CONTRA COSTA COUNTY

Contra Costa County Medical Society (reported by L. St. John Hely, secretary)—The regular meeting of the Contra Costa County Medical Society was held Thursday evening, May 28, at the Abbott Emergency Hospital, Richmond. Burt S. Stevens of San Francisco spoke on diseases of the pelvis. This was in the nature of a talk fest, bringing out situations we have to meet every day, and the management of which demands much diversity of opinion. Stevens showed that he is in possession of a vast amount of experience in diagnosis and treatment of pelvic diseases.

The attendance was small, due to the change of date for the meeting, and, therefore, no business was discussed.

FRESNO COUNTY

Fresno County Medical Society (reported by T. Floyd Bell, secretary)—The monthly luncheon of the Fresno County Medical Society was held at the Fresno Commercial Club May 23, with twenty-six members and two visitors present. Members—Drs. Aller, Anderson, Bell, Barr, Cross, Dahlgren, Dau, Ellsworth, James, Jorgensen, Kjaerbye, G. L. Long, Manson, Miller, Montgomery, Mitchell, Newton, Pettis, Pomeroy, Schattstaedt, Sciaroni, Sheldon, Stein, Tillman, Tupper, and J. R. Walker.

Lee S. Seward, director of the Tri-County Tuberculosis Hospital at Ahwahnee, presented an interesting and very instructive paper on "Errors in Diagnosis and Therapeusis in Tuberculosis." He said that the errors in diagnosis were largely due to careless physical examination. Many of the cases with cough were diagnosed as "heart cough" or asthma. Many of the old chronic cases of pulmonary tuberculosis take care of their infection pretty well, except for chronic cough, etc., but are a source of infection in the spread of the disease to others, especially children. The x-ray is a great help in diagnosis, but only an aid, and one cannot differentiate between an active and a quiescent lesion by the x-ray. The proper treatment for pulmonary tuberculosis is that type of treatment which promotes rest for the respiratory apparatus. The advice sometimes given to tuberculous patients to go to the mountains and "rough it" is very bad treatment. Likewise the undue forcing of foods is undesirable. Climate does not make as much difference as does the kind of treatment carried out, except that patients probably do better in that climate where they are most comfortable.

Numerous questions were asked, especially since Fresno County is contemplating additional means of taking care of its tuberculous patients. Seward gave a brief history of the Ahwahnee Hospital. He said that the cost per day per bed there was $2.79. This was about $1.36 more than the cost for such patients as taken care of at the various county hospitals. This additional cost was entirely for service rendered, no expense being spared to take care of cases at Ahwahnee. He said that Fresno County should have two tuberculous hospitals—one in the foothills for convalescents and a preventorium for children, and one in the valley for hopeless and advanced cases. He outlined a big program if the tuberculosis problem is to be handled properly.

Cross moved, Schottstaedt seconded, that a committee be appointed to investigate the advisability of erecting a tuberculosis sanitarium for Fresno County in the valley or foothills, and report by June 2. Carried. Ellsworth, Tupper, and Mitchell appointed.

The regular meeting of the Fresno County Medical Society was held June 2 at the nurses' home of the General Hospital. There were twenty-two members and six visitors present. Members—Aller, Anderson, Bell, Couey, Cross, Dau, Ellsworth, Ingram, Kjaerbye, Larson, Miller, Montgomery, Mitchell, Nedry, Nider, Pettis, Schottstaedt, Sheldon, Tillman, Tupper, J. R. Walker, and Wiese. Visitors—Dr. Tranter and members of resident staff of the General Hospital.

Dr. Ellsworth reported for the committee recently appointed to report on the proposed tuberculosis hospital for Fresno County. He stated that, due to lack of time, the committee wished simply to indorse the proposition of building a tuberculosis hospital, but that the matter of possible and desirable locations for the institution should be left for future consideration. He said that the committee wished to make a more detailed report later in the summer. The report was accepted.

President Anderson reported on several matters which came before the State Council recently at the Yosemite meeting.

Charles L. Tranter of San Francisco presented a paper on "Traumatic Surgery of the Nervous System," illustrated by lantern slides. Neurological surgery may be divided into two large classes: (1) Traumatic surgery, and (2) tumors of the central nervous system and neuralgias. The former are more common and are the subject of the discussion.

Tranter emphasized the cardinal and auxiliary symptoms in cases of head injury, and pointed out those cases which recovered without operation, those in which operation was imperative, and those which usually died anyway.

The methods of procedure, i. e., operations, as far as the brain is concerned, are three: (1) Repair of skull defects; (2) subtemporal decompression; and (3) removal of broken pieces of skull. He presented several cases of repair of skull defects with associated brain conditions, such patients either having epilepsy, or some other condition being present, such as aphasia. He showed slides demonstrating the use of the osteo-periosteal graft. The use of foreign substances to close defects is a thing of the past. He spoke of the importance of Cushing's method of subtemporal decompression in cases of increased intracranial pressure. He also said that most authorities now believe lumbar puncture is a harmless and valuable procedure in such cases, and should be tried before decompression is done.

Surgery of the peripheral nerves may comprise any one of five procedures: (1) Neurolysis, or the removal of scar tissue; (2) simple suture; (3) transplantation of nerve and suture; (4) resection of a partial neuroma; and (5) amputation of neuromata. Dr. Tranter discussed these different methods; also the technique of suturing, resection and stretching of nerves.

MARIN COUNTY

Marin County Medical Society (reported by J. H. Kuser, secretary)—The May meeting was held at W. F. Jones' office. H. O. Hund, W. F. Jones, C. W. Clark, O. W. Jones, and J. H. Kuser present. The delegate to the State Association being absent, the purpose of the meeting—a report by said delegate, Dr. Rafael Dufficy—could not be carried out.

SACRAMENTO COUNTY

The Sacramento Society for Medical Improvement (according to the report of E. S. Babcock, secretary pro tem.) met at the Sacramento Hotel, May 26; thirty members present. The minutes of the previous meeting were read and approved.

Charles E. Schoff reported a case of psoriasis in a Chinaman.

The paper of the evening on "Fractures, Their Diagnosis and Treatment" was read by Frank P. Brendel. A large number of lantern slides showing most of the common fractures and many uncommon types, with both correct and faulty reduction, and proper and improper plating, were shown to illustrate his excellent paper.

Royal de R. Baronides and J. W. Wilson were elected to membership in the society.

Considerable time was given to reports of the state convention, started by Delegate C. B. Jones. A communication from Secretary Bert Thomas, further reporting the convention, was read by P. W. Christman. Dr. Parkinson, Councilor Eighth District, gave a resumé of the following subjects: Optional medical defense; permanent location for annual meetings; conflicts in schedule of section meetings; certification of delegates and alternates; Officers Reserve Corps; on choosing the site for the Bunnell Memorial; income tax, as related to physicians.

SAN FRANCISCO COUNTY

St. Luke's Hospital Notes—The regular meeting of St. Luke's Hospital Clinical Club was held Thursday, May 14, J. Marion Read being the speaker of the day, and taking for his subject, "Prognosis and Choice of Treatment in Grave's Disease," his conclusions being based on an intensive study of one hundred cases seen by him during the past six years. Points brought out in discussion were: That diagnosis of this disease is easy, since basal metabolic determinations are obtainable almost anywhere, but since its etiology is still unknown, treatment still rests on an empiric basis; that it is about eight times more frequent in females than in males; that it has many atypical forms; that it often tends toward spontaneous recovery, which makes the valuation of therapeutic measures exceedingly difficult; that it is prone to run a cyclic course with periods of remissions and recrudescences; that its incidence is greater in goiter districts; and that there seems to be an irreducible minimum of mortality.

From a prognostic point of view, one may conclude that some patients will get well (the form of therapy employed receiving credit therefor); some will die, in spite of all therapy and some because of it; and there is a group in which therapeutic efforts may affect the ultimate outcome of the case to a slight extent. The metabolic rate is the best quantitative measure of the degree in which the condition exists. It is not possible to predict from the rate, however, the probable time limit of the disease.

This Clinical Club met again on June 11. The feature of the day's program was the practical demonstration by R. L. Dresel of an improved fracture bed. Dr. Johnson, superintendent of the hospital, in his preliminary remarks stated that for the past two years the hospital had been having a great deal of trouble with fracture beds; that for several months Dr. Dresel had been working on a standardization of fracture beds and splints, and that today he was prepared to demonstrate a bed that had been worked out under his supervision.

Dresel briefly outlined some of the difficulties encountered with the old fracture beds—they would not go into the elevators; they occasionally fell down while in use; they were expensive, from the standpoint of both equipment and labor; they had no permanent superstructure, whatever constructed when necessity arose being of a makeshift nature. He proceeded to demonstrate the strength and durability of the improved bed. He showed that it can be raised and lowered without disturbing traction; that it has a superstructure that will stay, and that it is not only a fracture bed but a foundation for many kinds of care. He went on to say that there had also been much difficulty with splints; they had been of all sizes and materials. Now they had been standardized and made to fit the bed; there were lengths to fit the children's beds, as well as the adults'. He closed his remarks with a request for criticism and for any suggestions for improvement that his audience desired to make.

St. Joseph's Hospital Notes—St. Joseph's Hospital staff, San Francisco, met June 10, A. S. Musante presiding, and heard Edmund Butler, chief emergency surgeon, speak on "Surgical First Aid," abstracted below:

"In a recent visit East the emergency service of many cities was observed, many of these being but the outpatient departments of the district hospitals, instead of independent departments. San Francisco ranks high in economy, promptness, and efficiency. We had 38,500 admissions last year, of which 29,500 were surgical.

Routine fundamentals for wounds are a careful exploration, mechanical cleansing without abuse of tissue, the removal of devitalized soft parts that are contaminated, judicious drainage, and the proper use of antiseptics, sutures and wet or dry dressings. Most are iodized and dressed with equal parts of glycerin and 95 per cent alcohol. Scalp wounds are inspected for foreign material. If the pericranium is torn, the skull is inspected for fracture, but the wound is not enlarged. In face wounds exact approximation, without wrinkling and angling, is obtained with sutures. Eyelid wounds must be handled gently and nicely approximated, to avoid bad scars. Fine round needles and horse hair and silk sutures are used and drainage with rubber tissue favored. In neck wounds, often suicidal, the mucous membrane of the pharynx is sutured with catgut, muscles with chromic and skin joined so as not to impede drainage, which is placed in the angles and midline. Stab, gunshot and crushing wounds of the chest are generally treated expectantly. Primary shock is great, but the prognosis is good. Blood is not aspirated early, as the compressed lung reduces movement and favors clotting; if allowed to expand, secondary bleeding may occur. All openings in the pleural cavities are closed at once—at first with a sterile towel wrung out of sterile salt solution and then with figure-of-eight silk worm sutures, including muscles, fascia and skin. Abdominal stab, gunshot and contused wounds require intervention. Ruptured spleen is misleading, as primary shock and low blood pressure allow clotting to occur in the tear, but in six to ten hours the blood pressure increases, the clots are dislodged and secondary bleeding ensues, accompanied by slight abdominal pain and distention and polymorphonuclear leucocytosis. Leucocytosis occurs in all bleedings into serous cavities and soft parts, and may reach 50,000. Intraperitoneal rupture of the bladder does not cause alarming symptoms, and the pain is often ascribed to contusions of the abdominal wall, enteritis or, in females, to salpingitis. Intervention, if delayed, has a high mortality.

Injuries to limbs make up most of emergencies. Simple fractures are reduced as completely as possible without anesthetic and immobilized with cardboard. In compound fractures the skin is shaved and prepared to wound and the end of bones, if protruding, cleansed and iodized. Drains, glycerin and alcohol compresses and immobilization are utilized. In lacerated wounds, few sutures, free drainage and above compresses are used. Cut tendons are sutured at once, or if patient has a physician, latter is notified at once, the wound shaved, iodized, compressed, and splinted. Burns are treated with antipyrexol."

Dr. Alex Keenan praised the fairness of Dr. Butler's service towards doctors and the excellence and immensity of its growth.

Dr. Samuel H. Hurwitz spoke on the "Modern Treatment of Asthma," the following notes being stressed:

"There are two main causes of asthma—idiosyncrasy to certain substances (proteids) and infections. Real asthma is distinguished from the dyspnoea of cardiac, renal, and other diseases. The foreign proteid substances can be taken in by such methods as ingestion, inhalation or absorption, and produce asthma, hives, and eczema. Certain foods—even essential ones—and emanations from domestic and other animals are causes of trouble. The diagnosis can be made by rubbing into the skin or injecting (too sensitive) suspected substances or their extracts to note reaction. If a wheal, itching or redness develops, it is indicative of a positive reaction. The history may disclose hereditary manifestations in early life. The onset may be noted after certain occupations (hostlers, bakers, etc.) are entered.

The prognosis for desensitization is good if the asthma is not of too long standing. Some metabolic factor, like dysfunction of ductless glands, may need correction and diet, and other hygienic measures may be needed.

The infectious group of asthmas may be due to respiratory tract origin, especially the sinuses, gall-bladder, and occasionally the kidneys. Certain groups are often recognized, like that of children after many respiratory diseases, that after influenza and that following a long history of bronchitis. The infectious type of asthma often does well. Treatment is based on the bacteriology disclosed by a careful sputum culture. Vaccines from the organisms found are used; if several, inject each one and those producing the most reaction will generally clear up the condition. The autogenous vaccines are best. Fifty million are injected every five to seven days, and even larger doses are then used. Surgical aids in removal of pathology should be considered. Climate makes but little difference. Both desensitization and vaccine therapy are used if indicated.

In the attacks of asthma, adrenalin and morphine sulphate are best."

Drs. Philip Collischonn and F. A. Lowe presented case histories of purulent bronchitis and pre-eclamtogenic toxemia, respectively.

SANTA BARBARA COUNTY

The American Association for Medical Progress, Inc. — The Santa Barbara branch of this organization was addressed by Mr. Benjamin C. Gruenberg, managing director of the American Association for Medical Progress of New York, and Walter C. Alvarez, M. D., of San Francisco.

Many of our most prominent citizens have taken memberships in this organization of laymen, whose object is to disseminate as widely as possible authentic information regarding the fundamentals of modern medicine, including the methods of research by means of which reliable knowledge is obtained as to cause, prevention and cure of disease.

"Full use of our best scientific knowledge," says President Coleman, "is possible only with the support and co-operation of the public, but such co-operation depends upon an appreciation of what scientific medicine and research mean. Ignorance, apathy and superstition are a menace to medical progress and *to the health of the people,* not only in actual opposition to scientific methods, but in a failure to understand the scientific attitude. This can be remedied by continuous education, and our people may thus be guarded against quacks and charlatans."

Mr. George E. Coleman is president; Mr. F. F. Peabody, chairman Lay Advisory Board; and Miss Pauline M. Finley, secretary-treasurer of the Santa Barbara County branch.

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SONOMA COUNTY

Sonoma County Medical Society (reported by G. A. Hunt, secretary)—A joint meeting of the Sonoma, Mendocino, and Lake County Medical Societies was held in the hospital of W. C. Shipley in Cloverdale, Thursday, May 14.

J. H. McLeod of Santa Rosa addressed the meeting on the "Nasal Accessory Sinuses." Many lantern slides were shown which helped to make Dr. McLeod's talk interesting and instructive to the general practitioner, as well as to the specialist. A general discussion followed.

CHANGES IN MEMBERSHIP

New Members — Alameda County — E. J. Finnerty, G. M. Kennedy, Oscar K. Mohs, Abilio Reis, Oakland; J. Elliott Royer, Berkeley.

Kern County—Kenneth M. Cook, Taft.

Marin County—Homer E. Marston, San Quentin.

Orange County—William C. Bruff, Anaheim.

San Francisco County — James F. Runner, Frederick Eberson, George F. Oviedo, William A. Blanck, San Francisco.

Santa Clara County—Hugo Schmitt, Palo Alto.

Solano County—Durward B. Park, R. I. Longabaugh, Vallejo.

Sonoma County—James C. Johnstone.

Deaths—Bronson, Edith. Died at Yosemite National Park, May 26, 1925, age 38. Graduate of Johns Hopkins Medical School, Maryland, 1913. Licensed in California in 1913. Doctor Bronson was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Cline, John Welby. Died at El Monte, May 14, 1925, age 57. Graduate of the University of Colorado School of Medicine, Boulder, Denver, 1896. Licensed in California in 1913. Doctor Cline was a member of the Los Angeles County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Horel, Francis R. Died at Arcata in April, 1925, age 74. Graduate of Rush Medical College, Illinois, 1885. Licensed in California in 1891. Doctor Horel was a member of the Humboldt County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Obituary

EDITH BRONSON

The recent death of Doctor Edith Bronson, Assistant Professor in the Department of Pediatrics of the University of California Medical School, takes from the medical profession of California a woman with exceptional training and brilliant attainments in the field of research. Born and educated in Vermont's schools and academy, she took her A. B. degree from Syracuse University and entered the Medical School, where although a classical student, she won her master's degree in zoology and chemistry. Her scientific interest in research determined her entrance at Johns Hopkins University, and in 1913 she won her M. D. degree there. Her first internship was in the Children's Hospital in San Francisco, 1913-1914. Her second internship was in the New York City Children's Hospital in 1914. With the war came that call to go overseas and serve with the countries already bearing the burden. Doctor Bronson went first to the Hospital for Sick Children in Edinburgh and during 1915-1916 served as a resident. While there the association with Dr. John Thomson and Dr. J. S. Fowler enriched and broadened her scientific work and earned for her the friendship and interest of these leaders in the field of modern pediatrics. 1916-1917 found Doctor Bronson a resident in the Children's Hospital at Paddington Green, London, and the following year a resident in the Children's Hospital at Pendlebury, Manchester. The war children with their bitter needs flowing from the great munition plants in the heart of industrial England drew from Doctor Bronson her finest and best. She worked with an intensity that left its mark upon her fine sensitive spirit. In 1918 and 1919 she became one of the outpatient physicians in the famous Children's Hospital in Great Ormond street, London, where again her association with such leaders as Sir James Mackenzie, Dr. Leonard Guthrie, and Dr. G. Sutherland brought fresh devotion to her work and won for her the respect and admiration of her chiefs. Late in 1919 Doctor Bronson returned to her work at the University of California Hospital and the Children's Hospital, where the brilliancy of her mind, the fineness of her spirit, the true discriminating sense of values in her work brought instant recognition. The study of heart conditions has been her major interest for a number of years and her contribution to the subject had already been noteworthy. "Nodules," "Fragilitas Ossium," "Aneurysms in Childhood," "Influenza Associated with Jaundice," "Physiotherapy in Heart Disease," are some of the published articles that firmly establish Doctor Bronson's place in research. Her death at the early age of 38 leaves the medical profession in California poorer and takes from the group of women physicians in Northern California one who brought to her work an enviable training and distinction.

Endameba Coli—Sixteen cases in which endameba coli (councilmania type) was found by J. H. Hall and A. C. Reed, San Francisco (Journal A. M. A., June 20, 1925), are here reviewed as to clinical history. The complaints and symptoms were more or less variable and indefinite, in many comprising a picture usually described as neurasthenia. The most frequent reports were of epigastric discomfort, flatulence and constipation, not accounted for by the presence of any discoverable organic lesion of the digestive tract. All patients had, as a routine, physical examination, history, blood count, Wassermann test, urinalysis, gastrointestinal roentgenograms, stool analysis and, frequently, gastric content analysis. Other group symptoms were even less definite, as general debility, fatigue, vertigo, neuralgic pains and physical discomfort. Most of these patients were middle-aged men. A routine treatment was used in this group similar to that employed against E. histolytica.

MURPHY MEMORIAL HOSPITAL AT WHITTIER AGAIN

The astounding developments growing out of the giving, building, and maintaining of the Murphy Memorial Hospital at Whittier, California, by Colonel Murphy have been commented upon in CALIFORNIA AND WESTERN MEDICINE and "Better Health," several times, and these comments have been widely reproduced in both scientific and more public literature. The outstanding facts are that Colonel Murphy had designed and built an unusually beautiful hospital at Whittier as a memorial to his father. Considerably more than a third of a million dollars was spent in construction alone. At the same time the benefactor made provision for doubling the size of the hospital later on again at his expense, and included a bequest in his will of $200,000 as an endowment in perpetuity to take care of citizens of the community who would not be able to pay the cost of good hospital service.

Colonel Murphy then entered into negotiations with the authorities of the city of Whittier by which he donated the hospital to the municipality under certain conditions. The outstanding feature of these conditions was, that the hospital was always to be maintained as a "Class A" hospital. This document was duly and as legally executed as it is possible to do, in dealing with our small town governments. The trustees, in carrying out the requirements for a first-class hospital insisted, as is required by the American Medical Association, American College of Surgeons, and all other good medical organizations, that none but educated doctors of medicine be permitted to practice in the hospital. This procedure aroused the ire of the many classes of cultists and those who do not believe in medicine at all as well, and through the usual legal machinery they brought the question to a vote of the people of the municipality. The cultists, aided, we are sorry to say, by a few licensed physicians, succeeded in carrying the election, the result of which was to treat the benefactor, who is still living, with discourtesy, to express it mildly, and to treat the official legal paper of the municipality as a proverbial "scrap of paper." This action opened the hospital to all and sundry.

The next stage in the development of this debacle was that Colonel Murphy, through his attorneys, made preparations to enter suit to declare the original trust void because of abrogation of contract on the part of the city, and demanded the return of his property to his estate. In the meantime, Colonel Murphy's health continued to fail and the lawsuit was given up and has now been withdrawn, and with that withdrawal the benefactor has deleted the $200,000 endowment which had been included in his will, and has otherwise amputated himself from the situation in the following letter:

"May 23, 1925.

Board of Trustees of the City of Whittier,
Whittier, California.

Gentlemen—Receipt is acknowledged of your letter of May 18. I cannot appreciate or agree with your position. I am addressing this final letter to you in order that the records of the city may clearly show that I do not concur with or acquiesce in the statements contained in your letter, or the manner in which you propose to operate the Murphy Memorial Hospital.

Your attitude absolutely ignores the condition in the original deed of gift that the hospital should be always maintained as a Class A hospital: namely, as a standardized hospital according to the high standards of the American Medical Association and the American College of Surgeons. It also ignores the absolute promise of the city (contained in the resolution of acceptance by the Board of Trustees of the city of my offer to build the new wing) that the hospital should always be maintained according to the high standards then established, which the records of the hospital show were exactly those of a Class A hospital, as above defined. I am convinced that the city is both morally and legally obligated to maintain these standards, and, had my health permitted me to continue my case against the city until it could have been tried upon its merits, I feel confident that the court would have so decided.

Common honesty and fair dealing require the city to maintain the hospital according to these standards, even though the city were not already legally bound to do so. Such being the condition of the gift, I do not believe that there is any merit in your claim that the law of the state of California requires you to do anything other than to live up to the terms and conditions of the gift, which permit anyone to practice in the hospital who has the requisite educational and ethical qualifications to practice in a standardized medical and surgical hospital.

Unless the hospital is maintained as a standardized hospital (which it will not be if practitioners licensed to practice any method of healing, or who are unethical in their practice, are admitted to its staff), the reputation of the hospital will rapidly dwindle and the people of the city of Whittier will not receive the high type of modern hospital service which it should have and which I intended to give it.

It is because of the attitude of the present officials of your board and of the present board of hospital trustees in lowering the standards of the hospital and in ignoring the city's agreement with me that I have lost my former keen interest in the hospital. It was because of such attitude, and because of my recent poor health and an expected trip to my home in Charleston, West Virginia, that I dismissed the suit against the city, without prejudice to my rights as donor. **Because of such attitude I feel that not only the money invested by me in the hospital is a loss, but that the hospital will no longer be the kind of a memorial to my beloved father and mother which I intended it to be. So I have caused their pictures to be removed from the hospital.**

My views have been so clearly set forth in this and my prior communications that there ought not to be the slightest misunderstanding as to my position, and as far as I am concerned, please let this letter finally close the matter. For these reasons, and because of my health, I do not desire any further discussion of the subject either by letter or interview.

Yours respectfully,
(Signed) SIMON J. MURPHY, JR."

Doctor H. P. Wilson, the personal physician and the personal friend of Colonel Murphy, who took such an intense interest in advising Colonel Murphy constantly in the various steps by which he had hoped to create a fine hospital to serve a small community, in forwarding the above letter from Colonel Murphy, says: "There is a distinct element among the best people of this community who are chafing under this thing and who still hope that the hospital may be restored to its former dignified status."

Needless to say that this hospital, at one time so full of promise, will not succeed in obtaining accredited standing before medical bodies until some assurance of the right kind of stability has been pledged and practiced under this pledge for a sufficient length of time and with earnestness of purpose and that kind of municipal regard for obligations not heretofore manifested.

This matter is given thus fully because it is no longer a little local problem for a small community in California, but has reached around the world in the news columns and editorial comment as one of the outstanding shames in modern health betterment.

WESTERN BRANCH AMERICAN UROLOGICAL ASSOCIATION

This organization held a meeting in connection with the session of the California Medical Association in Yosemite. The members were notified of the adoption of the new constitution.

The officers elected for the ensuing year were George Hartman, chairman; Anders Peterson, secretary; Louis Clive Jacobs, vice-president; J. C. Negley, treasurer.

A resolution recommending the holding of a special scientific meeting in San Francisco, either in October or November of 1925, was adopted. The following papers were presented:

"Bladder Disturbances and Lesions of the Nervous System"—Leon Meyers.

"Surgery of Tumors of the Bladder"—Verne Hunt.

"Carcinoma of the Urachus"—Paul Ferrier.

Utah State Medical Association

ACQUIRING MERIT

The Orientals have a saying when a man performs a kindly act or one contributing to the welfare or comfort of a fellow-being that he "acquires merit" thereby. The thought is one worth considering in its application to the association of human beings East or West, we think, and surely the officers of the State Association and the committee on education deserve great credit and have acquired much merit by the work done on the post-graduate course in connection with the annual state meeting in September, a full provisional schedule of which is printed in the body of these notes.

Times were when the standard of the county society or the state society, with rare exceptions, was that of the best informed man in the county or state. But times change. Today the possible standard is limited only by the knowledge of the profession at large. Modern means of communication and transportation have largely militated to this end. Too, there is a friendly, co-operative spirit growing up within our own ranks—a sincere desire to disseminate knowledge more than ever before.

There is, however, another way of acquiring merit. Enough that the committee has furnished the program—bigger, better, and more comprehensive than ever before in the history of the state. The duty now devolves upon every member of the profession within the commonwealth to avail himself of the rich mental banquet provided to his own betterment. This is bringing the university and college to his doors. The question is, shall he, will he partake? It is his moral duty to do so, for to him men and women and little children entrust daily their physical well-being—indeed, their lives. In the assuming of such a trust, surely no man should fail to equip himself with the best available knowledge. Does he not do so, he betrays a trust, and what true man would wish to so stultify either his profession or himself? It is to be hoped, then, that the medical men of Utah will let no avoidable consideration stand in their way in attending this course of intensive instruction—that they will hasten to arrange to be present, and that in so doing they will acquire merit for the days and months to follow. An ignorant physician is a danger to his patients—to his profession in this day and age, a disgrace. Literally, today the doctor is a soldier as much as he who wears a uniform and faces a barrage.

> "If ye break faith, we shall not sleep
> Tho' poppies bloom in Flanders' fields—"

Learn, work, rest. It is the doctor's as well as the layman's life.

And surely he who seeks to learn all he may, work truly and sincerely, may best rest, when his work is done, with a conscience clear and a knowledge that such merit as he may have acquired in the eyes of his fellows was deserved.

TROUBLESOME TENANTS

We medical men are troublesome tenants if the managements of office buildings are to be believed. We make so much elevator traffic with our patients, we make so much demand on the building service of light, heat, gas, water—in fact, everything. If we're surgeons, we have bloody dressings in containers which make the charwomen sick. If we do minor operations in our offices, we disturb the other tenants with the concomitant yells and shrieks our patients emit, or should we use an anesthetic the smell puts the stenos of the adjoining offices to sleep. Our office girls visit with other office girls (or boys) and demoralize the service in every possible way. As a matter of fact, we are a sort of gang to be tolerated and permitted to pay rent, under durance, in case the building happens to have some space it wants filled up.

Consequently, it is with a feeling of something like dazed amazement that we note two announcements affecting the medical tenant directly within the past week. First to come was the news that the C. A. Quigley building, a fourteen-story, modern office structure, to be erected in the congested district, will set aside six to eight floors for the use of "the Docs." Second is the news that, inside the year, it is proposed to erect an exclusive medical and dental building—the Medical Arts building, as now provisionally called—which will literally house nothing save the two professions. This is to be a ten-story structure, built entirely for professional needs.

"Ubinam gentium sumus!" Cicero exclaims, "Where in the world are we!" Can it be possible that we poor orphans are at last to be provided with home and shelter inside the coming few months? Yet, why not? The thing has proved successful in other cities. We feel sure that both enterprises will be appreciated and patronized by the professions in Salt Lake.

Utah Notes (reported by J. U. Giesy, associate editor) —*New Office Building*—It is announced that the C. A. Quigley building will soon be erected on Exchange Place. This will be a modern fourteen-story building in which six or eight floors are to be set aside for the needs of physicians and dentists. This is a welcome bit of news to the professions affected who for so long have felt the need of some such available space for offices designed and equipped for medical and dental needs rather than the makeshift arrangements of general office buildings for which physicians have been permitted to pay rent.

Salathiel Ewing, M. D., 1834-1925—Doctor Ewing, dean of medical men in Salt Lake, died recently of cerebral hemorrhage, at the age of 91 years. He was born in Union County, Ohio, December 24, 1834, and came to Salt Lake in 1883, where he conducted active practice until his death.

1925 Session U. M. A. Combined With Post-Graduate Week—This year the sessions of the State Medical Association will be combined with courses of graduate instruction, and the combined sessions will occupy the entire week of September 7 to 12.

Below will be found the provisional program of the post-graduate course to be held in connection with the annual meeting. We are proud to print this program. It touches the high mark of medical progress in Utah. It is

a golden opportunity knocking at the door of every sincere practitioner in the state. Read it and smile in anticipation.

"Some four years ago the Utah State Medical Association inaugurated the plan of having a week of clinics and inviting someone of eminence in the profession to conduct the same. The first two years were confined to diagnostic clinics in medicine; last year we added clinics in pediatrics and a review course in laboratory diagnosis; this year we are going further. The course will be combined with the annual meeting of the State Medical Association, and we will have an intensive week, covering the entire field. There will be papers, clinics, discussions, each day from 8 in the morning until 10 at night. Such a medical feast has never before been offered in this intermountain country. Those who will conduct this course are men of outstanding eminence in the profession. There will be work for the specialist; there will be work for the general practitioner remote from the aids of the up-to-date laboratory, x-ray, etc.; there will be work for everyone. You cannot afford to miss what will constitute practically an intensive six-day post-graduate course almost at your door.

A nominal registration fee of $10 will be charged for the clinical course.

Date: September 7 to 12, 1925.

The following will conduct the course. A mere recital of the names is convincing proof of the excellence of the program:

Walter C. Alvarez, Professor of Research Medicine, University of California Medical School.

Joseph C. Beck, Professor of Otology, Rhinology and Laryngology, University of Illinois College of Medicine.

William F. Braasch, Professor of Urology, University of Minnesota Post-Graduate School of Medicine, Mayo Clinic.

Russell D. Carman, Professor of Roentgenology, University of Minnesota Post-Graduate School of Medicine, Mayo Clinic.

George B. Eusterman, Professor of Gastro-Enterology, University of Minnesota Post-Graduate School of Medicine, Mayo Clinic.

Alexius M. Forster, Chief of Staff, Cragmor Sanitorium for Tuberculosis.

Martin F. Engman, Professor of Dermatology, Washington University Medical School.

Carl A. Hamann, Dean and Professor of Applied Anatomy and Clinical Surgery, Western Reserve University School of Medicine.

Julius H. Hess, Professor of Pediatrics, University of Illinois College of Medicine.

Edward Jackson, Professor of Ophthalmology, University of Colorado School of Medicine.

John L. Porter, Professor of orthopedic Surgery, Northwestern University Medical School.

Ernest Sachs, Professor of Clinical Neurological Surgery, Washington University Medical School.

Final program announcing subjects will be mailed.

Your early registration is earnestly suggested.

Any further information will be cheerfully furnished."

THE ANNUAL MEETING AND POST-GRADUATE WEEK IN OUTLINE

Monday, September 7

8 to 9

Laboratory; Blood Count; Urinalysis.

9 to 12

Papers—Dr. Eusterman, Dr. Carman, Dr. Hess.

12 to 2

Meeting—House of Delegates.

2 to 6

Papers—Dr. Hamann, Dr. Braasch, Dr. Engman.
Meeting—House of Delegates.

8 to 10

Papers—Dr. Jackson, Dr. Beck.

Tuesday, September 8

8 to 9

Laboratory; Blood Chemistry.

9 to 12

Papers—Dr. Alvarez, Dr. Calonge, Dr. Hess, Dr. Sachs.

12 to 2

Meeting—House of Delegates.

2 to 6

Papers—Dr. Porter, Dr. Forster, Dr. Sundwall, Dr. Eusterman, Dr. Carman.

8 to 10

Banquet.

Wednesday, September 9

8 to 9

Laboratory; Serology.

9 to 12

Papers—Dr. Hamann, Dr. Alvarez, Dr. Engman.

2 to 6

Papers—Dr. Jackson, Dr. Porter, Dr. Sachs, Dr. Braasch.

8 to 10

Papers—Dr. Eusterman, Dr. Carman.

Thursday, September 10

8 to 9

Laboratory; Bacteriology—Sputum Examination.

9 to 12

Clinics—Dr. Hamann, Dr. Braasch, Dr. Engman.

2 to 6

Clinics—Dr. Porter, Dr. Sachs, Dr. Beck, Dr. Hess.

8 to 10

Clinic—Dr. Alvarez.

Friday, September 11

8 to 9

Laboratory; Gastric Analysis; Feces.

9 to 12

Clinics—Dr. Hamann, Dr. Alvarez.

2 to 6

Clinics—Dr. Hess, Dr. Eusterman, Dr. Carman.

8 to 10

Clinic—Dr. Forster.

Saturday, September 12

8 to 9

Laboratory; Tissue Diagnosis.

9 to 12

Clinics—Dr. Alvarez, Dr. Hamann.

2 to 6

Clinics—Dr. Forster, Dr. Hess.

All meetings, clinics and laboratory demonstrations will be held at the University of Utah.

Luncheon will be served at the University dining-hall daily.

The papers and clinics of Drs. Jackson and Beck will be on subjects of interest to the general practitioner.

EYE, EAR, NOSE, AND THROAT SECTION

Monday, September 7

12 to 2

Luncheon.

2 to 6

Papers or Clinical Talks—Dr. Jackson, Dr. Beck.

8 to 10

Papers—Dr. Jackson, Dr. Beck.

Tuesday, September 8

9 to 12

Papers—Dr. Beck, Dr. Jackson.

12 to 2

Luncheon.

2 to 6

Papers or Clinical Talks—Dr. Jackson, Dr. Beck.

Wednesday, September 9

9 to 12

Paper—Dr. Jackson.

12 to 2

Luncheon.

2 to 6

Clinic—Dr. Jackson.

Thursday, September 10

9 to 12

Papers—Dr. Beck.

12 to 2

Luncheon.

2 to 6

Clinic—Dr. Beck.

Papers and Clinics will be at the University of Utah, unless otherwise posted.

Salt Lake County Medical Society (reported by M. M. Critchlow, secretary)—At the meeting of June 8 President Brown announced the appointment of A. A. Kerr,

chairman, and Willard Christopherson and B. E. Bonar members of the committee to investigate the Visiting Nurses' Organization. Dr. Kerr reported for the committee and recommended that the Salt Lake County Medical Society endorse the organization of the Visiting Nursing Association if it were properly managed. The report was referred to the Committee on Public Health and Legislation for their action.

T. C. Gibson reported for the Committee to Supervise Public Lectures. Fred Stauffer reported for the Building Committee. F. B. Steele reported for the Library Committee. The secretary announced that the American Medical Association auto emblems have arrived.

A special meeting was called for June 16 to hear a representative of the American Birth Control League.

A telegram from James F. Percy was read, announcing that he could address the society if they wished. An invitation was extended to Dr. Percy to talk at a special meeting.

The following men were elected delegates to the Utah State Medical Association for two years: T. A. Flood, G. F. Roberts, L. N. Ossman, John Z. Brown, J. P. Kerby, F. H. Raley, S. D. Calonge, E. D. LeCompte, and R. R. Hampton. The following were elected delegates to serve one year: S. C. Baldwin and E. L. Skidmore. The following were elected alternates: G. N. Curtis, L. A. Stevenson, and Foster J. Curtis.

Special Meeting—A special meeting of the Salt Lake County Medical Society was held at the Commercial Club Thursday, June 11, 1925. Thirty-nine members and two visitors were present.

President John Z. Brown introduced the speaker of the meeting, Dr. James F. Percy of Los Angeles, California.

Dr. Percy talked on "Heat in Cancer." He discussed the history of the cautery. He described his technic in cancer operations using his cautery. He cited many cases from his own experience, showing the advantage of cauterization over the usual method of dealing with malignancy.

His very interesting and instructive paper was discussed by Byron Reese, F. S. Bascom, A. Lipkis, A. A. Kerr, Clark Young, and A. C. Callister.

May 11—Sixty one members and fourteen visitors were present at this meeting.

The scientific program was presented by members of the County Hospital staff, F. E. Straup presiding.

Ray T. Woolsey demonstrated some x-ray films of multiple pregnancy. Edwin R. Murphy presented a case of spasmophilia with laryngospasm and discussed the differential diagnosis and treatment. B. E. Bonar discussed a fatal case of diaphragmatia hernia in the new-born and showed pictures of the pathological specimen. He also showed films of enlarged thymus glands and outlined the clinical history of such a case treated by x-ray. Ralph Tandowsky showed a case of erysipelas and read an instructive paper based on a study of one hundred cases of this disease. George F. Roberts presented a case which had recovered from epidemic spinal meningitis. He discussed the treatment used in the recent epidemic. His case was discussed by G. H. Pace, R. T. Jellison, F. E. Straup, Frank Boucher, and G. E. McBride. Newton Miller presented two cases of scalp wounds and discussed the treatment. C. W. Woodruff presented an undiagnosed case of enlarged spleen. A patient 80 years old, who had been operated on for strangulated hernia, was presented by W. E. Maddison, and the surgical treatment of this condition was outlined by J. C. Landenberger. A case of stone formation in the bladder, due to foreign body, was presented by E. S. Pomeroy, and also a case of perineal fistula cured by dilatation of the urethreal stricture.

Guy Van Scoyac showed a case of miners' consumption and a case of advanced pulmonary tuberculosis which had responded to calcium treatment.

These cases were diseussed by H. S. Scott, George E. Robison, John Z. Brown, J. C. Landenberger, F. E. Straup, and George W. Middleton.

Fred Stauffer reported for the building committee, and outlined a plan for financing the ten-story building.

May 25—Fifty-six members and three visitors were present at this meeting.

The secretary read communications from the American Birth Control League, Inc., and the State of Utah Mormon Battalion Monument Commission. No action was taken on either of these communications. He also read a communication from the American Medical Association referring to the auto emblems, and one from Miss Ruth Olson with reference to a position in a doctor's office.

J. C. Landenberger presented a clinical case. The man was struck by lightning, rendering him unconscious, producing superficial burns over the front of the body. He showed the man's clothing, which was peculiarly ripped and torn by the lightning. General discussion followed.

E. L. Skidmore discussed "The Insulin Treatment of Diabetes." He outlined the management in order to determine the tolerance, the administration of insulin, instructions to patients, symptoms of overdosage, treatment of coma and complications. He presented a clinical case which had been treated with insulin for three years. Ralph Pendleton, Mazel Skolfield, and A. A. Kerr discussed Skidmore's paper.

A. J. Hosmer's paper was on "The Acute Abdomen." He sighted many cases from his own practice, discussed the differential diagnoses, time for operation, and technic. The differential diagnoses of surgical conditions was discussed in detail. This instructive paper was discussed by S. H. Allen and E. L. Skidmore.

The applications of L. C. Potter and W. N. Cain were voted upon and they were elected to membership.

President Brown announced that the Visiting Nursing Association wanted a member of the Salt Lake County Medical Society on their board.

William T. Cannon moved that a committee of three be appointed to investigate the proposition and report at the next meeting. Seconded and carried.

Nevada State Medical Association

W. M. EDWARDS, M. D., Mason.....President
CLAUDE E. PIERSALL, M. D., Reno.....
Secretary-Treasurer and Associate Editor for Nevada

THE 1925 SESSION OF THE N. M. A., ELKO, SEPTEMBER 4 AND 5

The 1925 meeting of the Nevada State Medical Association will be held at the Elko General Hospital, Friday and Saturday, September 4 and 5.

It has been announced to a number on our program that it would be September 11 and 12, but the dates are changed so that our program will not conflict with the Utah State Medical meeting and post-graduate course, which will be held September 7 to 12, inclusive.

Friday, September 4, we will have a luncheon at the General Hospital, and Friday evening at the theater, a movie on pulmonary tuberculosis. Saturday evening we will have a real banquet at La Moile, such as we had there in 1921; Saturday will be devoted not only to papers, but to clinical demonstrations. Sunday, September 6, we will have a fishing trip which the Elko County Society maintains may be the best that can be had anywhere in the United States.

The following is a quotation, in part, of Dr. W. A. Shaw's letter to the secretary, dated April 25, 1925: "We intend to have the finest meeting that has ever been put over in the state of Nevada. We put over a meeting in 1921 that we figured could be equaled, but not excelled; Reno apparently excelled our meeting at Bowers Mansion in numbers only. We, in Elko County, shall put on a meeting in September which will be written in the history of the Nevada association and which will also be remembered enthusiastically by all the medical men who attend."

Our Nevada members are urged to present clinical cases, to write to your secretary for a tentative program, then decide what subject you will present or discuss. All members and visitors who are to present a paper or clinical demonstration are urged to send to the secretary a resume of your subjects as early as possible so that those listed for discussion may be be prepared for the same.

The Elko Society will provide space for exhibitors.

No member may present or discuss a paper if his dues are unpaid.

The Washoe County Medical Society (reported by

Henry Albert, secretary)—A meeting was held on June 9, with President Vinton A. Muller in the chair.

Dr. Carl H. Lehner's application for membership was referred to the Board of Censors.

A communication from W. C. Woodward of the A. M. A., relative to urging those in charge of the reduction of federal taxes to consider "The discontinuance of the war tax imposed on physicians under the Harrison Narcotic Law by the Revenue Act of 1918," and also "The right to deduct certain professional expenses in the computation of the physician's income tax, which is equivalent to imposing a tax on the activities out of which such expenses arise, namely: (a) A tax on attendance at meetings of medical societies, and (b) a tax on post-graduate study," was read.

A motion to the effect that the Washoe County Medical Society indorse the spirit of this communication and that the secretary be instructed to write to the President of the United States, the Secretary of the Treasury, and to Nevada's representatives in the United States Senate and the House of Representatives, informing them of the action taken, was passed.

Doctor Ernest H. Falconer of San Francisco addressed the society on "Some of the Causes of the Enlarged Spleen." He discussed more especially the leukemias, Hodgkin's disease, splenic anemia, pernicious anemia, hemolytic jaundice, and polycythemia. The address was illustrated with lantern slides and was discussed by Doctors S. Bath and Albert.

Members in attendance were: Albert, Bath, Brown, Caples, Fuller, Lewis, McLean, Muller, Piersall, Samuels, Servoss, Tees, West, and Doctor Lehners was present as a guest.

CALIFORNIA BOARD OF MEDICAL EXAMINERS' NOTES

(C. B. Pinkham, M. D., Secretary)

Health Fakers as of Old—Although we fully realize the hopeless stupidity of a lot of our "health educators" and are fully cognizant of the flamboyant propaganda and unutterable rot that is ground out in an endless stream and labeled health information, we nevertheless had hoped that after a half generation of such tremendous activity some progress was being made. We had hoped that our "speedy positive health propaganda" would at least enable us to say that Barnum's well-known dictum was at last obsolete. However, there is hardly a mail delivery but what contains stories that cause us to wonder if we really are elevating mass intelligence.

Just recently, a resident of an attractive little town in California became ill and formed the idea that he had a tumor. Instead of going to one of the educated physicians of his community, or even one of the thousands in a nearby city, he went to see a woman of the neighborhood who, according to a newspaper, "combined the business of vending hot tamales with the prescribing of herbs for the illnesses of her customers." This "doctor," it is reported, "told the patient that she could cure him, that it was not a tumor from which he suffered, but that he had in his stomach an animal that lived in a round ball, that the animal had broken out of the ball and was loose in his stomach, and that for the sum of $40 she would remove the animal and he would then get well. The patient had but $35 and he offered the "doctor" that amount, but she refused to treat him until the $40 was paid in advance, so the patient borrowed the other $5 and paid the $40. He then went to the home of the "healer" where, on account of limited room, two patients occupy the same bed, regardless of what diseases they may have. The "healer" gave the patient some liquid medicine to drink and put a mustard plaster over his abdomen. On the second day she told the patient she would remove the animal, but that in his weakened condition it would be too much of a shock to him to see what a terrible animal lived in his stomach, *so he was blindfolded.* A woman patient in the same room was also in too serious a condition to see the terrible animal come from the other patient *so she was blindfolded.* An emetic was then given the patient who became very sick and vomited into a pan. After he had recovered slightly, the blindfold was removed and he was allowed to see the animal that had been removed from his stomach. He says he didn't feel the animal come up his throat, but he saw it in the pan, that it had four legs and was partly black in color, and that, although he doesn't know the name of the animal, he has often seen such animals on the rocks in the ocean (probably a small crab). The sick man felt better after "the animal was removed," but the next day the "healer" told him that the ball that the animal formerly lived in was still "under his liver" and that it would have to be removed before he could hope to be entirely well, that it had been necessary to remove the animal first and it would take an entirely different kind of medicine to remove the ball; this would cost $20 more. The sick man didn't have the other $20, so it is presumed that the remnants of the ball still remain "under the liver."

Medicine Before the Bench

Findings and Comments of the Courts on Acts and Omissions of Doctors

(EDITOR'S NOTE—*The law reports contain many interesting decisions, involving the reputations and fortunes of doctors. In this column in each issue a brief summary of one or more decisions and comments of the several courts of last resort upon the cases will appear. The matter will be selected by our general counsel, Hartley F. Peart, who, with Hubert T. Morrow, attorney for Southern California, will contribute from time to time.*)

The Legislature at its last session passed an act which becomes law under the signature of the Governor on April 24, 1925, which empowers judges of the Superior Court to call in experts of all kinds to give testimony in cases requiring expert evidence. The law has been added as Section 1871 of the Code of Civil Procedure. The new section is as follows:

Experts; Appointment of by Court or Judge; Compensation; Manner of Examination as Witnesses. Whenever it shall be made to appear to any court or judge thereof, either before or during the trial of any action or proceeding, civil or criminal, pending before such court, that expert evidence is, or will be required by the court or any party to such action or proceeding, such court or judge may, on motion of any party, or on motion of such court or judge, appoint one or more experts to investigate and testify at the trial of such action or proceeding relative to the matter or matters as to which such expert evidence is, or will be required, and such court or judge may fix the compensation of such expert or experts for such services, if any, as such expert or experts may have rendered, in addition to his or their services as a witness or witnesses, at such amount or amounts as to the court or judge may seem reasonable. In all criminal actions and proceedings such compensation so fixed shall be a charge against the county in which such action or proceeding is pending and shall be paid out of the treasury of such county on order of the court or judge. In all civil actions and proceedings such compensation shall, in the first instance, be apportioned and charged to the several parties in such proportion as the court or judge may determine and may thereafter be taxed and allowed in like manner as other costs. Nothing contained in this section shall be deemed or construed so as to prevent any party to any action or proceeding from producing other expert evidence as to such matter or matters, but where other expert witnesses are called by a party to an action or proceeding they shall be entitled to the ordinary witness fees only and such witness fees shall be taxed and allowed in like manner as other witness fees. Any expert so appointed by the court may be called and examined as a witness by any party to such action or proceeding or by the court itself; but, when called, shall be subject to examination and objection as to his competency and qualifications as an expert witness and as to his bias. Such expert though called and examined by the court, may be cross-examined by the several parties to an action or proceeding in such order as the court may direct. When such witness is

called and examined by the court, the several parties shall have the same right to object to the questions asked and the evidence adduced as though such witness were called and examined by an adverse party.

The court or judge may at any time before the trial or during the trial, limit the number of expert witnesses to be called by any party. (In effect 90 days from and after April 24, 1925.)

CORRESPONDENCE

HOW YOSEMITE VALLEY IMPRESSED ONE PHYSICIAN'S WIFE

By M. B. P., *San Diego*

[*If all our guests enjoyed the trip to Yosemite as did the San Diego member's wife who sends us this communication signed with her initials, we might do well to make the "valley" permanent convention headquarters.*—EDITOR.]

Yosemite Park is beautiful. No praise that it has had could overdo the subject. To stand on one of those neat paths and look about at the green meadow or watch the clear, flowing river, and then gaze aloft at the imposing "Dome," or see the high rampart of Sentinel Rocks, fills one with praise for the Creator. Then look down at one's comfortable surroundings, and a calm assurance steals over one that all is well in the world. Mankind may enjoy its beauties and be thankful, as much as in him lies, to know that water is abundant for our needs, beauty is here to rest the weary, surprises are ready to give thrills, trees have grown for shade or shelter, flowers are abundant to lead mankind forward with desire for color, grace and charm.

When riding on the winding drives the visitor notices how inviting they look. There are lights and shadows ahead and tall straight pines looking permanent, and small graceful trees swaying to beckon the traveler. The roads are enticing. The woods are delightful, yes, full of delight. The deep steady-flowing river adds charm to many a vista. The waterfalls which leap into Yosemite Valley are every bit as wonderful as they have been painted. The Vernal Falls seem to get the most praise. The Yosemite Falls make a roar which is louder than visitors expect. When the quantity of water increased, the roar increased, but the eye could not detect much difference. The Cascade Falls are rollicking, jolly, vociferous, and happy looking. The Bridal Veil Falls are well named, for the way the water appears at the top as if coming over a head, but at the base the spray and cascades and rapids where it dashes over rocks among trees makes the beholder think only of how wet it is and full of water because he gets the spray.

The chief benefit of a visit to this marvelous valley might well be found in the effect on a small human being when he looks up the sheer high walls of tremendous height and feels awe creep into his very soul. He must look up to his Creator, marveling in such glorious works.

When riding out of the valley to El Portal the beauty is continuous for many miles, and then following down the shore of the Merced River it is attractive with trees on the banks and many curves and numerous rapids, but finally it grows less interesting.

Perhaps it is as gentle a let-down as one could ask.

A New Idea in Pharmacy Advertising—A firm of Spokane pharmacists have secured national publicity because they have inaugurated a new line of advertising. They call themselves "professional pharmacists" and "prescription specialists," and instead of using their paid space to boost patent medicines, hair dyes, beauty promoters, and such, they employ their space to carry helpful health messages to their patrons. One of their advertisements calls attention to dangers inherent in the indiscriminate use of iodine to prevent goitre; another carries a sane message about insulin and its uses, and still another urges people to have a medical examination periodically *and to have it done by their family doctor.*

ANOTHER POPE TRAVELOGUE

Simson's Camp, Tanganyika,
Via Nairdi, B. E. A.,
April 30, 1925.

My dear Dr. Musgrave:

We are here in the permanent camp of Simson. It is the last untouched game field of Africa. We are located on a high plateau, five or six thousand feet elevation. The morning and evening are cool, the grass plentiful, and isolated thorn trees shade the place. A score of grass huts shelter us and our native porters. There are about twenty-five of these in camp, and no women. The nearest village is thirty-five miles distant. This is Ikoma, once a Portuguese slave market, now only a collection of huts and a few aborigines.

Since coming to camp we have hunted every day. Great migratory herds of wilderbeasts are swarming over the country, zebra bark their short pertussus cough all night around our huts, hyenas titter and wail and laugh, jackals chatter and lions rumble and grumble in the distance. And because of the great number of wilderbeast, I presume that we see ten thousand a day, the lions are plentiful. All night they make their kills and wander home gorged in the early morning hours. We have seen to date eighty-nine lions. Of this number we have killed twelve. Two of these we killed outright with our bows and arrows, and two more we gave mortal wounds to, and they were dispatched to spare them misery. Eight lions have charged us to date. Four of these we stopped at distances less than five yards. Some of these beasts charged without any more provocation than snapping a camera at them, at distances from thirty-five to sixty-five yards. Either they were fretful females, mostly those who had vicarious interests in cubs, suffered insult by proxy, the usual spinster aunt complex, or they were old lions that had recently been deposed and wounded in a family fight, therefore sour on the world at large. I presume this is a dangerous life, but it all seems rather detached, as though it were a section of a cinema film. When they come on they roar and pound the ground like a running quarter-horse. One came in so close he flung himself in a great somersault right in our midst and fell dead ten feet beyond us as we sidestepped.

Smaller game we have not paid much attention to yet. A Thompson's gazelle, three hyenas, a checta, a baboon, and a horny badger for the Los Angeles museum, complete our bag to date.

I've carefully studied the gall-bladder and ducts of all these animals—also Topi, Eland, Zebra and Kongoni—for the Mayo Research Department.

Thus far we are in excellent health and can recommend this sort of life for anyone seeking a complete rest with plenty of exercise.

Very cordially yours,

SAXTON POPE.

Mercurochrome-220 Soluble in Genito-urinary Diseases—Of the 525 cases on which F. H. Redewill and J. E. Potter, San Francisco (Journal A. M. A., June 20, 1925), report twenty-nine patients left before treatment was completed. This leaves 496 patients, of whom only twenty-two were not improved or 4.4 per cent of the series. Of the remaining 474 patients, only twenty-four, or 5 per cent, were cured with mercurochrome alone given intravenously. This shows that only in a very few urologic cases can one depend on mercurochrome alone when given intravenously to effect a cure. Nor can one expect with such a maze of symptoms and pathologic conditions as are manifested in the practice of urology that a drug given only by way of the blood stream can be a "cure-all." In scores of these cases, however, by giving topical applications, deep instillations and irrigations of mercurochrome in conjunction with the intravenous medication, remarkable results have been obtained. In nineteen out of twenty-nine arthritis cases and in half the cases of acute gonorrheal rheumatism, marvelous results were obtained with the first few treatments of mercurochrome intravenously. The development of the diphenylcarbazid test for mercury and the mercurochrome kidney function test has materially decreased the number of cases listed as "not improved."